CHEMIST & DRUGGIST

The newsweekly for pharmacy

July 27, 1985

a Benn publication

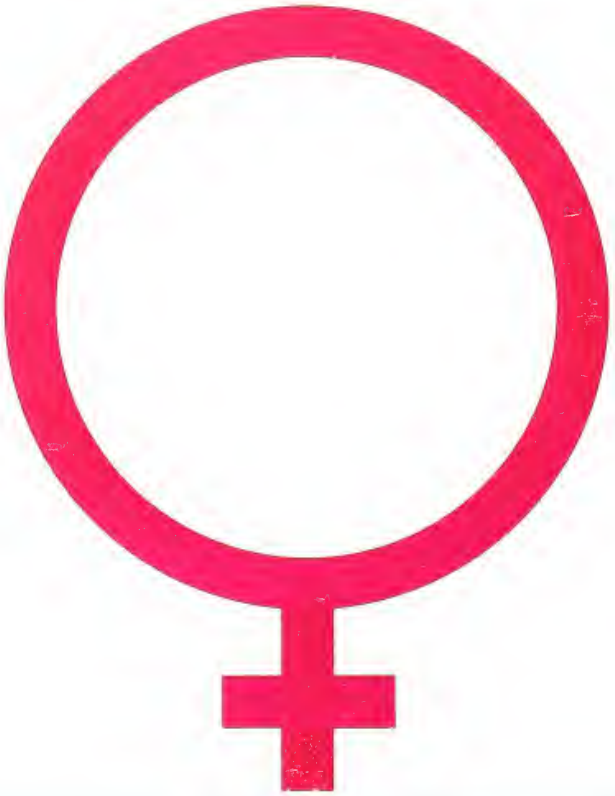
They Trust Your Advice for Treating Head Lice. And with new Suleo Lotions, compliance has never been easier.

Until now, eradication of children's lice has always been a worry for mothers. They believe the strong, pungent smell of traditional lotions is an instant flag to others that the family has lice. And because 12 hour contact was recommended, this often resulted in extra laundering of school hats and pillow cases.

But now, you can be much more confident of parental compliance with a louse control regime because International Laboratories have introduced Suleo-M Lotion (with malathion) and Suleo-C Lotion (with carbaryl). This new Suleo lotion range kills head lice and eggs in two hours. After this time, the patient's hair can be washed with an ordinary shampoo. This ten hour advance in speed of treatment enormously enhances the prospect of full patient compliance.

Suleo-M and Suleo-C Lotions. A Major Step Forward in Louse Control.

Another Guaranteed Product from International Laboratories



half the women in Britain could benefit from Cymalon.

So could all the Pharmacists.

a surprising number of women in Britain suffer from cystitis.

Surprisingly enough the treatment for the symptoms has been almost as unpleasant as cystitis itself.

until now. Because now there's a pleasant tasting treatment. It's called Cymalon.

bought without prescription, it's just mixed with water to make a lemon flavoured drink.

from July until October we're spending over £400,000 on a national T.V. campaign.

and as it's the first time ever a treatment is being advertised, everyone will be spending a lot of pennies in your shop.

CYMALON IS A REGISTERED TRADE MARK OF STERLING HEALTH.

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COMMENT

When will the leaked drafts of the new contract regulations and guidelines become the final draught community pharmacists are anxious to imbibe? Probably this week, as PSNC stands by to hear the Minister's comments on the draft bearing what it hopes will be the final amendments (p148).

What the health circular makes quite clear is that no pharmacy practising when the new contract becomes law has an automatic right to exist. The pharmacy practice subcommittee has no remit to refuse any new applicant a contract because of his proximity to an existing pharmacy. The governing principle is to be that the public must have a "reasonable but not excessively generous access to the full range of NHS pharmaceutical services" — the needs of the people being the "prime determinant". The applicant also has to demonstrate the inadequacy of the services provided by existing contractors.

The FPN says a "possible loss of income by an existing contractor, caused by the opening of an additional pharmacy is not of itself a relevant consideration. The only consideration is the impact on NHS services *including those already in existence*" (the italicised words are extra words wanted by the PSNC) insofar as their loss would disadvantage the public.

So although indiscriminate leapfrogging will no longer be allowed, new contracts could be granted to the detriment of a pharmacy, particularly if it is shown to give a poor service or to be sub- PSGB standard, provided that the net effect is an improvement in NHS pharmaceutical servcies. However, the PPSC will be able to refuse permission for ancillary services — oxygen, appliances etc — the very stuff of the new role in "stage 2".

And by refusing to consider the need for primary care services when a new application is being considered, or indeed the reduction in them when small contractors accept compensation, the Government and the profession is in danger committing sections of the Governments' Green Paper to a still birth. Factory script farms may not be the best place for the giving of good health advice. It's a step nearer a managed pharmaceutical service and a retrograde one at that.

Meanwhile the Company Chemists Association, Underwoods, Safeway and Pharmacists Against the Contract soldier on — Boots having taken care to keep their head below the CCA parapet. It remains to be seen whether the threatened litigation will materialise when the Regulations are laid, or whether limitation of contract will stifle a reasonable development of pharmaceutical services and act as a ligature on new contractual blood in the way protesters fear.

So pharmacy is on the brink of getting the rational location it has long sought. But the degree of rationality will ultimately depend on the ability of individual PPSCs to interpret fairly *and* rationally what are necessarily fairly flexible guidelines.

Still doubts as draft guidelines finalised

What the Pharmaceutical Services Negotiating Committee hopes is the final draft of the Regulations controlling entry to the pharmaceutical list was being considered by the Minister of Health last weekend.

It is unlikely the Regulations will now be laid before Parliament rises for the Summer break. But they can be laid during the recess — the beginning of August is a likely time — and still become operative on October 1 as planned. Any prospective leapfroggers are likely to be deterred by a clause requiring them to have shown financial commitment to opening a pharmacy prior to May 28.

PSNC was still waiting to hear the Minister's comments on Wednesday as *C&D* went to press. The likelihood of further negotiations is understood to be small.

A PSNC spokesman said Department officials had listened sympathetically to the points raised by both PSNC and the Pharmaceutical Society at a tripartite meeting last Thursday.

Health Minister Kenneth Clarke announced in the Commons on Tuesday the broad details (see right) of the new Regulations. "I intend this new scheme to come into operation at the earliest date possible. Consultations should be completed in two or three weeks. Regulations will then be laid."

Last week he said representations from the Company Chemists Association, Boots, Underwoods, Safeway and 13 individual contractors were "coming from a dissatisfied minority of contractors."

However, the CCA and Underwoods are still very unhappy with the current situation. "It is quite improper to restrict pharmaceutical services to just those under the NHS," CCA chairman Keith Ackroyd told *C&D*. "To think in terms of pharmacies being in places where there is only NHS business is quite wrong."

The proposals did not take account of commercial reality, he said, and would not help pharmacy adapt to future shopping trends. "That handicap will not be placed on drug stores."

It is also clear that the Minister is not about stopping leapfrogging, Mr Ackroyd said. "It has always been our view that the contract would not stop leapfrogging. It's significant because this was the point that got it accepted in the beginning."

Brian Kerner, Underwoods managing director believes PSNC has "been sold a complete pup". He does not believe independent contractors have got what they want (see p172). "There is nothing to prevent leapfrogging — the independent is giving away his birthright. I believe PSNC should withdraw quickly."

Leaked draft FPN awaits approval

An insistence that only NHS pharmaceutical services should be considered when an application for an NHS pharmacy contract is made is one of the most striking points in the draft health circular giving guidance on the proposed control of entry Regulations.

An edited version of the FPN, which would implement the NHS (General Medical and Pharmaceutical Services) Amendment (No 6) Regulations 1985, is given below. The Minister's comments on the draft were being awaited by PSNC as *C&D* went to press. *C&D* believes it will be published at the beginning of August with little, if any, alteration. Minor amendments sought by PSNC are included.

1. The NHS (General Medical and Pharmaceutical Services) Amendment (No 6) Regulations 1985 provide for a national system of local control of entry to NHS contract.

2. The objective is to provide a mechanism whereby the number of NHS pharmacies is determined by the needs for NHS pharmaceutical services by the local population. Only the NHS needs of the local people are to be the prime determinant.

3. There are no hard and fast rules for determining the number and distribution of pharmacies. FPCs are recommended not to adopt norms, average figures, nor to establish fixed rules, eg distance from another pharmacy. The governing principle should be to provide people with reasonable but not excessively generous access to full range NHS pharmaceutical services. New applications must demonstrate the inadequacy of services provided by existing contractors.

4. There is no Government target for the number of contracts, either nationally or locally. In some areas there may be a need for additional contracts — in others there is evidence of superfluity and a reduction would not diminish services. It must not be regarded as obligatory to replace any who elect to give up the contract. The new provisions will not prevent an existing contractor from transferring his contract on the sale of his business.

5. FPCs should adopt a flexible approach — local needs will change and service provision must adapt accordingly. These provisions must not fix rigidly the pattern of service, nor create a closed shop for existing contractors.

6. Each FPC is to establish a pharmacy practice subcommittees (PPSC). Its membership is a lay chairman, who must be an FPC member, three non-pharmacist members of the FPC and three pharmacists or pharmacy contractors (PSGB wants "pharmacy contractors" deleting). Deputies are to be chosen in like manner. FPCs will ensure a broad spread of membership. (PSGB want adding "A non-contractor pharmacist shall be included").

7. The FPC shall delegate its functions of control of entry unconditionally and must refer every application.

8. The PPSC's proceedings must be scrupulously disinterested. No person who has any interest in the outcome may take any part.

9. "Interest" means both a direct or indirect personal interest, including any pecuniary interest, whether or not arising from any NHS contract.

10. LPCs should supply a list of not less than seven pharmacists or pharmacy contractors who are willing to serve as members or deputies.

11. Previous experience in planning may be useful, and FPCs may consider this in making FPC appointments.

12. The FPC shall make standing orders in respect of terms of office, procedure and reporting. The PPSC shall elect one member to act as vice-chairman provided he is not a pharmacist or pharmacy contractor (PSNC/PSGB insist the vice-chairman be appointed under the same circumstances as the chairman). A quorum is the chairman (or vice-chairman) plus two pharmacy members and two other members who are not. At all times there must be equality between pharmacy and non-pharmacy members.

13. The PPSC may hold oral hearings and/or conduct site visits if desirable. Paid representation is not permitted.

14. The PPSC is set up to consider whether an additional pharmacy should be admitted to the pharmaceutical list. The issue is whether there will be a significant improvement in the NHS service bearing in mind existing services. The PPSC has no locus to consider any aspect of dispensing by doctors.

15. The PPSC may offer advice or information to the FPC or to other subcommittees if it wishes.

16. FPCs are permitted to combine the Hours of Service subcommittee and the PPSC, and they are recommended to do so. There should be no common membership among full members of the PPSC and the dispensing subcommittee.

17. Where several applications are received for the same or similar locations the applications should be normally considered on a first come first serve basis.

18. All applications must include the location of the new premises, and whether the contractor

- **Only NHS needs to be considered**
- **No firm rules for determining number and distribution of pharmacies**
- **No target number of contracts**
- **Flexible approach required by FPCs**
- **Recommendation to combine PPSC with Hours of Service committee**
- **Applications processed first come, first heard**
- **Possible loss of income by an existing contractor not in itself a relevant consideration**
- **Minor relocations at PPSC discretion — not necessarily distance dependent**
- **Appeal Panel to reverse wrong decisions — not substitute judgments**
- **Rural applications to go through PPSC then RDC**
- **Contractor must provide services within nine months**
- **Prior financial commitment required for interim.**

wishes to provide any ancillary services. The PPSC may reject some or all of the applications to provide ancillary services.

19. The FPC will invite comment from the LPC, CHCs, and FPCs whose boundary is within one mile of the proposed premises, and any pharmacy contractor who could reasonably be expected to have a significant interest in the outcome of the application as far as his NHS business is concerned. Contractors should be informed in sufficient time for them to register an interest and comment.

20. The 30-day period allowing for comment runs from the date of despatch of notification to interested parties.

21. Anyone who does not comment at this stage has no right to comment later.

22. The PPSC must consider every application, and decide whether the services proposed are necessary or desirable to the provision of adequate NHS pharmaceutical services in that locality.

23. The main or primary criterion is whether the proposed pharmacy would effect a real improvement in the local NHS pharmaceutical services. There can be no mechanistic approach to such a decision. Each decision must be firmly based on the facts of the local circumstances. A possible loss of income by an existing contractor is not itself a relevant consideration. The only consideration is the impact on NHS services, including those already in existence.

24. A number of factors need to be take into account. Some are listed below:-

(a) the pattern of natural communities and the normal pattern of travel.

(b) existing patterns, eg the number and location of existing NHS pharmacies and the possible effects on the NHS services they provide — the numbers of scripts and their sources — local demography, especially the presence of any group which makes above average use of primary care services, seasonal trends — ease of access (distances from homes and doctors' surgeries to pharmacies are highly relevant but should not be taken alone) — evidence of local deficiencies in the service (eg proven unwillingness of existing contractors to fulfil a stated need, or to maintain standards as defined by the PSGB).

(c) anticipation of future developments, eg known firm plans for development or changes in the pattern of population — known firm plans for changes in the number and/or source of prescriptions — known firm plans for developments which would affect local social traffic, (eg shopping centres) — health authorities' plans for development of services (eg community care)..

25. NHS pharmaceutical services only must be considered.

26. The PPSC has a duty to ensure that it has the necessary information. FPCs are producing strategies for the development of primary care services, and the key document bringing the factors outlined in para 24 together is the strategy produced by FPCs every five years.

27. Applications to relocate must be made in the form specified in the Regulations.

28. A minor relocation can be approved without the 30-day consultation period if,

(a) The population served in the new location is essentially the same as that served in the existing location and the NHS services provided are the same.

(b) No other existing contractor or potential contractor whose application has already been granted would suffer significant detriment which would prejudice his continuing ability to provide his contracted NHS services.

(c) the contractor provides NHS services without break from one location only, except only those days when the premises would not in any case be open.

29. This provision is to permit the acquisition of new premises eg on expiry of a lease, when the existing location is covered by a compulsory purchase order, to permit a contractor to move to better premises or respond to changing patterns of patient need (a change of doctors' surgeries or in shopping habits) without need for a new application. It is the fulfilment of the conditions in para 28 which render the relocation "minor" not the distance over which the business is relocated.

30. If the PPSC is not satisfied that a relocation is minor, the application must be regarded as one for an additional contract and the full procedure observed. A fresh application is not required.

31. The decision of the PPSC on an application for a new contract or that a relocation is minor must be notified to those set out in para 19. Those notified of the decision may lodge an appeal, except that in the case of an application for a new contract that person must have registered an interest at the consultation stage. The appeal must be posted within 14 days (PSGB wants 21 days), or in the case of a minor relocation, 21 days.

32. To be valid an appeal must state the grounds for the appeal and be neither frivolous nor vexatious — if it is it will be rejected without a hearing.

33. The FPC must convene an Appeal Panel to consider any valid appeal. Its composition will be the same as the PPSC, members being drawn normally from more than one FPC in the same NHS Region. No member may come from an FPC which has previously commented on the application.

34. It is not the function of an appellate body simply to substitute one judgment for another — it must reverse obviously wrong decisions. No appeal should succeed unless it can be shown that:

(a) there was a procedural defect of consequence at the earlier stage.

(b) new evidence is available.

(c) the original decision is clearly mistaken in that it cannot be supported by the facts, or its implementation would be detrimental to NHS pharmaceutical services. Loss of income to an existing pharmacy contractor is not of itself the criterion. The relevant consideration is whether an existing contractors' ability to to provide the NHS services he is contracted to provide would be prejudiced.

35. The Appeal Panel should determine its own procedure and may hold oral hearings and/or make local visits.

36. The FPC must ensure that valid appeals are given a full hearing, and respect the independence of the Appeals Panel.

37. All the above procedures apply universally and invariably to all applications. In areas which are not controlled localities (rural areas) the decision of the Appeals Panel is final.

38. In controlled localities an applicant must have the consent of both the PPSC and the RDC. An applicant successful at the PPSC stage will have the application referred to the RDC. The existing RDC procedures apply in full. The decision of the RDC (or Secretary of State on appeal) is final.

39. An application unsuccessful at the PPSC stage (and/or Appeal Panel) will not be referred to the RDC.

40. In controlled localities where the decision of the PPSC and/or Appeal Panel is that the proposed pharmacy is neither necessary nor desirable that decision is final.

41. A successful contractor must begin to provide the services specified within nine months of application. He must notify the FPC that the premises are registered, are under the supervision of a pharmacist and the date he intends to commence practice. The contractor becomes bound by the Terms and Conditions of Service from that date. If a contractor fails to provide services within nine months the application fails. If the applicant can show good cause why the period should be extended (eg delayed building work) then the FPC may grant an extension of up to another nine months.

42. Decisions are to be reached quickly. It should be exceptional for a PPSC decision to take longer than two months and for an Appeal Panel decision to take longer than three months.

43. A prospective applicant may make informal preliminary inquiries of the FPC, which should supply reasonably promptly any relevant information available. This is a non-statutory provision and no advice is binding.

44. For a limited period the existing arrangements for entry should continue to apply to prospective contractors who can show that they had a firm financial commitment to the development of a pharmacy before the details of a new contract were made public. Any applicant who can prove that he had a financial commitment (eg possession of a lease or a freehold) before May 24, and that he was committed to opening a pharmacy at those premises (eg a restrictive covenant) and who undertakes to open that pharmacy not later than March 31, 1986 can be admitted to the list.

Safeway get BRA support

Safeway are getting support in their opposition to the new contract from the British Retailers Association, which represents all the leading multiples.

Mr Tom McNally, the Association's director told *C&D* that a number of the multiples had expressed concern over how it would effect their future plans.

"Safeway have taken the lead and a number of larger retailers are now considering developments with chemists in them," he said.

"We have written to Lord Lucas, the Under Secretary at the Department of Trade and Industry, saying there is a wider interest and would he make sure that these were taken into account."

Mr McNally says that the BRA would press for a debate if they could not get any joy from the Minister. "I think it is a matter of public interest if pharmacy is going to be restricted," he said.

"In some ways PSNC and the DHSS are both vested interests. I can understand why both sides want to do a deal but that should not be the end of the matter.

He finds the October 1, deadline for the introduction of the Regulations "very unsatisfactory".

"They should be delayed until the wider issues have been discussed," he said. "We are after wider consultation and are pressing for a delay in implementation".

PAC drops its fees again

Pharmacists Against the Contract has again reduced its joining fees as the recruitment drive continues.

Proprietors are now asked to pay £75, employee and hospital pharmacists £17.50 and students £7.50. The reduction is because there was some resistance to the £250 fee originally sought, and because of PAC's reduced need for cash.

Chairman Alan Nathan says membership is growing. "Our appeal is widening," he says. "We have signed up hospital pharmacists, employees and even students." He says PAC now has over 300 members.

He says the statement last week by the Pharmaceutical Society (*C&D* last week, p97) made interesting reading.

"They are now saying the very things we have been campaigning on since the beginning," he says. "Expressing concern for small contractors and the future pharmacists who would not be able to start in business".

PAC have organised another London meeting (see *Coming Events*) and are still arranging others around the country.

Live animal tests down

There were some 125,000 fewer experiments done on living animals in 1984 than the year before.

Home Office figures released this week show that 3,497,335 experiments were started in Great Britain in 1984. The majority were done on mice (1,903,859). Tests for cosmetics and toiletries accounted for 17,512 animal experiments. Medical, dental and veterinary product and appliance tests accounted for 1,915,700 experiments. Application of substances to the eye accounted for 12,975 experiments, 7,751 of those were done on rabbits.

Health Minister Kenneth Clarke announced in the Commons last week that the LD_{50} tests for actinomycin D would no longer be necessary.

The Government, along with other members of the Council of Europe last week agreed the text of a European Convention for the protection of laboratory animals.

Home Secretary Leon Brittan told the Commons that the Convention would be open for signature in the Autumn, when the UK would sign.

Mr Brittan described "The European Convention for the Protection of Vertebrate Animals used for Scientific Purposes" as the first attempt in Europe to lay down common minimum standards.

The Convention aims to balance the needs of scientific research with the consideration due to live animals; to protect them from pain and suffering whenever possible, and to ensure that non-sentient alternatives are used whenever practicable.

The NHS (General Medical and Pharmaceutical Services)Amendment (No 5) Regulations 1985 (SI 1985 No 1053, HMSO £1.35) enable an FPC to apply to the Secretary of State for directions as to recovery of overpayments to doctors and pharmacists. The Regulations come into effect on August 1.

Fighting drug abuse with NPA

There is scope for pharmacists to become involved with the fight against drug abuse, particularly at local level.

In recognition of that the National Pharmaceutical Association is planning to stimulate interest among members through branch officials as part of its 1986 PR campaign. NPA director Tim Astill told *C&D* that there is scope for involvement in all kinds of health prevention.

The NPA helps out on an informal basis with statistics or data or local contacts for pharmacists giving talks on drug abuse for example.

Problems of illicit drug use were highlighted in BBC television's Drugwatch programme last week.

Esther Rantzen told viewers that a recent survey they had done showed that 9 per cent of the respondents had taken drugs; that equates to at least 4 million nationally, most under 35 years old.

On average each drug user tried ten different drugs. Some 62 per cent had taken their first drug by the time they were sixteen years old.

The most frequently used drug is cannabis with nine out of ten in the survey saying they had taken it, compared to around half who had tried heroin.

But the second most frequently abused drug identified was amphetamine — four out of five in the Drugwatch survey had tried it. Use was widespread, not just confined to cities but also in rural areas — "even the Highlands of Scotland".

Mr Astill pointed out that the quantity of illicit drugs on the market originating from pharmacy break-ins is minuscule. Over-prescribing by doctors had more of an influence. There has been a downward trend in the number of pharmacies raided for drugs, Mr Astill said.

The maximum penalty for production, supply and possession with intent to supply Class A drugs (essentially opiods and cocaine) has been increased from 14 years to life. The legislation was introduced as a Private Member's Bill — the Controlled Drugs (Penalties) Bill — by Keith Raffan and received Royal Assent last week.

Xylotox 2 per cent E80 2.2ml dental cartridges, batch number KM4225, should be returned to wholesalers for replacement. Cartridges in the batch may have large air bubbles and extruded bungs, say Astra Pharmaceuticals Ltd, Home Park Estate, King's Langley, Herts, WD4 8DH.

Taking stock 'In the City'

This week *C&D* starts a new series. In the City, appearing for the first time on p169, provides a guide to the main happenings on the London's Stock Exchange over the past month. We will be concentrating particularly on performances in the pharmaceuticals sector, but also hope to give a picture of the wider market. Whether you are looking at your own investments, or just want to keep an eye on the fortunes of the companies whose products you sell, join us ... In the City.

"I can't understand it — he always used to be a *Sun* man!"

Opren users sue CSM

The Committee on Safety of Medicines is being sued by patients who say they suffered side effects from Opren — withdrawn in 1982.

Some 200 writs have been issued and the Opren Action Committee, representing the patients allegedly harmed by the drug, claims to have evidence that the CSM failed to give adequate protection to the public.

Manufacturers Eli Lilly and its British subsidiaries have been served writs. A spokesman for Lilly in Britain told *C&D* the matter was in the hand of their lawyers.

The action committee also claims that it has evidence that Sir Abraham Goldberg, CSM chairman, did some work on benoxaprofen as an investigator, before he became a member of CSM. But there is no suggestion that he acted illegally, behaved improperly or had any financial interest in the drug.

Labour MP Jack Ashley has called for a public inquiry. He has written to the Prime Minister saying that the issues to be examined should include relationships between members of the CSM and drug companies, the secrecy of the CSM deliberations and criteria for granting product licences and the efficacy of clinical trials.

The DHSS refused to comment on the action saying it was now sub-judice.

CD appeal to House of Lords

The House of Lords is to hear an appeal to decide the position of pharmacists who unknowingly dispense Controlled Drugs on forged prescriptions.

London pharmacists, Storkwain, were last week given leave to appeal to the Lords against a Court of Appeal ruling last May, that the Medicines Act 1968 imposed a strict liability on chemists, making them open to prosecution in the courts even if unaware that a prescription is a forgery.

The Court of Appeal ruling was the result of a successful appeal by the Pharmaceutical Society against a decision by a Wells Street magistrate not to convict Storkwain of unlawfully selling Controlled Drugs from their premises in Edgware Road, Paddington.

The Lords are expected to hear the case later this year or in early 1986.

Double fault, says ASA

A complaint against Revlon's "Charlie tennis sweepstake" promotion has been upheld by the Advertising Standards Authority.

A member of the public claimed that an entry and three letters of inquiry were not acknowledged and objected that there was inadequate administrative support for the scheme.

Revlon were asked by the ASA to ensure that future promotions should be backed by adequate administration. The company then sent the information and offered the complainant a supply of products.

The ASA has upheld, in part, a complaint against a Bayer UK Press advertisement. The complainant said that the advertisement, headlined "How good were the good old days?" quoted exaggerated statistics about mother and child mortality in the 19th century. The ASA noted that Bayer's sources were broadly supported with regard to infant deaths, but that the claim of "one mother in five" dying in childbirth was based on unrepresentative research. The company was asked not to suggest, in future use of debatable figures, that the information had universal support.

The ASA received 7,733 complaints from the public in 1984 — an increase of 185 on the previous year.

According to the ASA's annual report, a total of 867 cases concerning the Sales Promotion Code were examined, and of these 142 involved toiletries products and 16 involved infant and medical. Areas which caused the Authority "concern" included a failure to give enough details of competitions and lack of prominence given to general information.

The product areas in which copy advice was most frequently sought during 1984 include cosmetics and toiletries, hair products and treatments, therapies, slimming and medicines.

A new edition of the Advertising Practice Code is expected to be published this year, and includes revised rules concerning political advertisements.

Off the hook

The Government does not intend to use the Medicines Act to restrict the general availability of alternative medicines, Health Minister Kenneth Clarke has told MPs.

The Licensing Authority will not require formal clinical trials for herbal, and other medicines, intended for minor self-limiting conditions, when their licences come up for review, he said. The Authority will rely instead on existing bibliographical information. The Department of Health is currently engaged in discussions with herbal manufacturers.

Under EEC requirements it is necessary for medicinal products already on the market when the licensing system began for new products in 1971, to be reviewed by 1990.

This includes herbal medicines, but not homoeopathic or other alternative medicines, which will not be reviewed until after 1990 except in special cases.

CHEMIST & DRUGGIST

CHEMIST ASSISTANT OF THE YEAR COMPETITION

Look out for details next week — new prizes and a new reward for knowledgeable assistants

TOPICAL REFLECTIONS

By Xrayser

Free movement agreed by EEC

Proposals for free movement of pharmacists agreed by EEC Ministers on Tuesday have been welcomed by Mr Tim Astill, director of the National Pharmaceutical Association.

"I cannot imagine that there will be substantial movement of pharmacists," Mr Astil told *C&D*. "It's a good thing we have the new NHS contract which will enable control over the granting of NHS contracts," essentially the same as controlling openings, Mr Astill said.

There were fears that free movement may bring about a distortion in the Community with movement from countries where there was rational location to those where there was not. In fact an amendment was passed, such that member states could refuse to register foreign pharmacists opening new premises. That is now academic for the UK of course.

The agreement will not apply in Greece for another 12 years, according to the *Financial Times*. Greece fears it may be swamped with pharmacists. Indeed, Greece has been mainly reponsible for holding up the agreement.

Company refunds £2m to DHSS

One pharmaceutical company has refunded around £2m to the Department of Health in the past two years as excess transfer price profits.

The latest report from the Public Accounts Committee looking at the Pharmaceutical Price Regulation Scheme acknowledges the "limited success" achieved in recovery of excess transfer price profits, and emphasises the "continuing importance of thorough investigation".

The Committee concludes that in the "unavoidable absence of clear criteria for setting target profit levels, it is ultimately a matter of judgment and should remain under regular review".

The next review should take account of the limited list.

The Committee noted the DHSS felt the review board rate was an important factor in setting profit rates, but was not a determinant. It also recognised the difficulty faced by the DHSS in ensuring a fair balance between NHS and industry.

Pricing

I inserted the most recent Pharmaceutical Society recommendation on private script dispensing in those cellophane folders you can buy at stationers and placed them in a handy ringfile, which sits next to my prescription book. I find it easy to use, logical in its charging assumptions and offering sufficient return to be accepted as fair for our professional input. It is profoundly disappointing, therefore, to find from an independent survey whose results were published last week, that there are still pharmacies who feel the need to overcharge.

We have one near us. They regularly "enhance" the basic price by anything from 100 to 200 per cent. The locals eventually "suss" them out and come out of their way to me or my nearest competitor colleague, but many visitors get ripped off. I would hope to see Society inspectors looking at the prices charged in the private sector when they examine the script books, and where necessary drawing particular attention to this. Boots seem, at last, to have left behind those days of undercutting all private chemists in all spheres of activity professional. I accept their modest undercharging on the sample shown, (whose consistency indicates adherence by staff to set procedures) as due to an internal delay in adopting the latest recommendations by Society.

Rural leaps

Dorset, as a county, seems to have its fair share of rural problems. Maybe it just has an active LPC. But I imagine there must be considerable unhappiness at the recent granting of outline consent for a new pharmacy to open in the attractive Georgian town of Blandford. It is not a year since I visited this area and, of course, being a pharmacist, noted the position of the pharmacies and wondered how successful they were? I always rather fancied owning one of those substantial country town businesses for social, as much as economic reasons, since they must draw on a fascinating cross section of the population. But, if my recollections are correct, this proposed opening would appear to be smack in the middle of the town, between the two existing shops, and neatly intercepting the flow of patients. A pure unadulterated leapfrog.

Looking at the Rural Dispensing Committee decision to grant outline consent forced me to go back to see exactly what terms of reference applied to RDC considerations. The decision they made would appear to have been inevitable, since they are bound to grant the application so long as it does not prejudice... "the *proper* provision of pharmaceutical services." Nowhere does it require them to be concerned with the prejudice, or otherwise, to *existing* pharmaceutical services. Looking at it coolly, the responsibility of Government is to make sure a proper service is provided. It doesn't matter to them whether any established service is wiped out so long as overall cover is provided.

When you read the leapfrogging company signed the lease several months ago, one becomes aware of how confident they must have been of the apparent legal position. Yet I find the decision unsupportable, and consider it one which the RDC should not have made, in light of the well advanced negotiations on the new contract with the substantial safeguards offered by the DHSS and the Minister himself. They ought to have referred this to the Minister.

More pricing

I'm not complaining. I'm not trying to cause problems. I am concerned, though, at the slowness of the prescription pricing bureaux in doing their work. For the last few months I have been getting estimated payments for my scripts. (I send them promptly, I may add.) It's alright to get an estimated 100 per cent but some of the adjustments are a bit disturbing, when you find you have less cash in the bank than you thought. It's all very well for them to blame staff shortages and extra work due to the HD scheme.

Interest in O_2

The Pharmaceutical Services Negotiating Committee has had a "very good" response from contractors wanting to act as sub-agents for the new oxygen concentrator service being introduced on December 1.

"A large percentage are prepared to be agents," according to PSNC spokesman Peter Boardman, "and we can now tender on that basis." Tenders have to be in by the end of the month.

PSNC are still hoping for national coverage, but the Department of Health is understood not to want a monopoly supplier.

Whether the PSNC's bid is regarded as such is uncertain.

Gillette go for Aapri skin

Following the launch of their deep cleansing Aapri facial scrub in 1983, Gillette are making a bid for a larger share of the skin care sector with the introduction of Aapri washcream (125ml, £1.49), moisturising lotion (100ml, £1.89) and cream (50ml, £1.89).

A £1.7m television advertising campaign will support the launch nationally in September and October. This will be backed up by a £120,000 women's Press campaign running alongside.

Aapri washcream is a daily facial cleanser formulated for use with water. As with all the other products in the range it is fragrance free, and its pH balanced formulation of pure ingredients makes it thorough enough to be effective but gentle enough not to dry the skin, say Gillette.

The moisturiser is available as both a cream and a lotion, containing pure apricot oil. Like the facial scrub, they will be targetted at 18-35 year old women.

All three are presented in white containers with the orange and green Aapri symbol, and come in orange and white cartons.

Trial sizes of the washcream (30ml), cream (15ml) and lotion (30ml) will be available for £0.69 each. Other promotional activity includes distribution of 2.5 million free sample sachets and 2 million money off coupons between September and February. POS material is available in sizes suitable for all types of stockists say, *Gillette UK Ltd, Great West Road, Isleworth, Middlesex.*

Five duettes

Five new creamy powder eyeshadow duos, have been added to the Innoxa line-up, featuring Colour Reflections — the new colours for Autumn.

The new shades which include midnight blue and dawn pink, peacock and gold leaf will be available from September. New colours are also available in Jewelfast lipsticks and nail enamels. *Innoxa (England) Ltd, 202 Terminus Road, Eastbourne, East Sussex NN21 3DF.*

Best support ever say Horizon

Horizon describe their latest D&P support programme as, "The most ambitious and attractive consumer promotion ever offered by the photo dealer."

Every customer who brings their film to a Horizon dealer between now and August 31 will get a free £20 holiday discount voucher. The vouchers are valid for any ABTA holiday booked before the end of 1987.

Customers with vouchers then qualify for Horizon's competition with their next order. This gives them the chance to win a Sanyo teletext colour television plus a video recorder, or one of over 50 other prizes. *Horizon, Argyle Way, Stevenage, Herts.*

Rash move!

A sampling scheme to health visitors and welfare professionals has started for Vasogen nappy rash cream.

New 14g samples in light weight plastic tubes will be distributed along with copies of a new leaflet "The nuisance of nappy rash". Shelf talkers and a free customer leaflet are available from *Pharmax Healthcare Ltd, Bourne Road, Bexley, Kent DA5 1NX.*

How to present your customers with an overnight sensation!

BUY 100 TRAVEL PACKS – AND WE'LL SUPPLY TWO DISPENSERS FREE!

Travel Packs are fast becoming an indespensible item on every traveller's list. Ideal for overnight stops, or prolonged journeys, they are both light and easy to carry, and yet full of those easily-forgotten essentials.

There are two designs – the 'Vanity Pack' for women, and the 'Overnight Pack' for men; both are beautifully packaged and prominently display their contents to the customer.

And now, as a special offer, to help you catch the eye of every prospective traveller, we will supply you with two free dispensers with every 100 packs (50 of each design) that you purchase. So contact us now, place your order, and watch that overnight sensation take place!

Ladies Vanity Pack

Toothbrush	Nail File	Cotton wool
Toothpaste	Mouthwash	Moisturised Wipes
Shampoo	Safety Pin	
Comb	Hairgrips	

Gentlemens Overnight Pack

Toothbrush	Comb	Disposable razor
Toothpaste	Nail File	Shaving Cream
Aftershave wipe	Shoe Shine	

PHONE NOW!
Tel: 01-387 4484

TO Postal Centres (International) Ltd., Goodyear House, 52-56 Osnaburgh Street, London NW1 3ND
VAT No. 403 407 985

POSTAL CENTRES INTERNATIONAL

Please send me _____ lot(s) of 100 Travel Packs (50 male, 50 female) at £95 + VAT + postage and packing at £3.50. I claim my two FREE Dispenser units. I enclose total cheque for_____

Name_____

Address_____

CD/7

AFTER THE NATIONAL T.V. CAMPAIGN...

STOCK FARLEY'S NEW RUSKS WITH WHOLEMEAL AND IT'LL BE HEALTHIER FOR EVERYONE!

YIKES! I DIDN'T KNOW THERE BE SUCH A STRONG DEMAND

YUM! THEY'RE SO TASTY- GET SOM OR I'LL EAT YOU FOR BREAKFAST


MICK
YANK!
Farley's
NEW
Rusks
Enriched with Vitamins & Minerals
18
Rusks
WITH
WHOLEMEAL
'S SO GOOD

Novaprin®
a brand of
Ibuprofen
at prices that make sense

20 tablets 98p
trade price 56p

50 tablets £1.96
trade price £1.12

Counter Prescribe
Novaprin®
for
RHEUMATIC PAIN
Novaprin is recommended for fast, effective relief of rheumatic pain, muscular pains, sprains, period pains and flu symptoms.

U.K. Distributor
David Anthony Pharmaceuticals
Speke, Liverpool Tel: 051 486 7117

Beecham add unisex gel

Silvikrin hair setting gel — a unisex styling gel designed for fashion-conscious young people — is being launched by Beecham Toiletries with heavy promotional support.

Packed in a transparent, vertical 125ml tube (£1.25), the clear blue gel provides "extra-strong, greaseless control and hairstyles remain intact all day long or throughout the evening," says Mike Fensome, Beecham Toiletries general manager.

The product will be promoted by a sampling campaign through youth-orientated national magazines read by both sexes and cinema advertising in London.

"The UK styling gel market is expected to be worth £10m (rsp) in 1985, having trebled in value within the last two years. The field is currently only being serviced by a number of small, virtually unpromoted products without unisex appeal, the bulk of which are own-label", says Mr Fensome. *Beecham Proprietaries Toiletries, Beecham House, Great West Road, Brentford, Middlesex TW8 9BD.*

Dynasty comes to the chemist

Carrington Parfums, a division of Charles of the Ritz, are launching the fragrance Forever Krystle, based on the character of Krystle Carrington of Dynasty fame.

The fragrance is described as a "warm oriental bouquet with a delicate balance of bergamot, neroli, orange flower and subtle notes of mimosa, muguet, rose and jasmine". The range comprises: perfume (30ml, £75; 7.5ml, £30), and eau de toilette spray (50g, £12.95; 22g, £7.95; 14g, £5.95, 50ml, £12.50). The one ounce perfume is presented in a crystal-cut bottle. *Carrington Parfums, 51 Charles Street, London W1X 7PA.*

Shulton's Xmas offerings

Shulton have a choice of Christmas gift sets for their new Insignia fragrance — splash on lotion with talc or with spray deodorant, both retailing at £2.99.

Also available as Christmas gifts are the executive collection set of Pierre Cardin after shave balm and lotion (22ml), travel soap, talc and shampoo in a smoked perspex travel case (£9.95); and the Pierre Cardin pour Monsieur gift box containing after shave spray, soap and talc (£17.95).

The Pierre Cardin Choc fragrance gift set consists of parfum spray and talc (£14.95).

Blue Stratos sets combine splash on lotion, shampoo, deodorant, aftershave and talc (£3.85 to £4.59). *Shulton (Great Britain) Ltd, Shulton House, Alexandra Court, Wokingham, Berks RG11 2SN.*

Krups add on...

Krups are introducing two new hot brushes and a hairdryer to their collection of haircare appliances. Existing products in the range have been repackaged and the livery changed.

The Turbo 1000 hairdryer (£6.95) has a detachable styling nozzle and two power settings, 500W and 1000W.

The Quick Chic Plus (£7.95) blows steam through the barrel — an additional feature which Krups say will help create longer-lasting curls. It also has a swivel-mount flexcord and curl release button.

The Quick Chic (£3.95) has an extra thin rod, to allow for tighter curls. *Krups (UK) Ltd, Motherwell Way, West Thurrock, Grays, Essex RM16 1DX.*

... and Jo-ba

Jo-ba have introduced an anti-dandruff shampoo for dry/normal hair and normal/greasy hair. The product comes in a 250ml bottle and retails at £1.59. *Jo-ba Ltd, Vincent House, Garman Road, London N17 0UR.*

Vestric show ad-Vantage

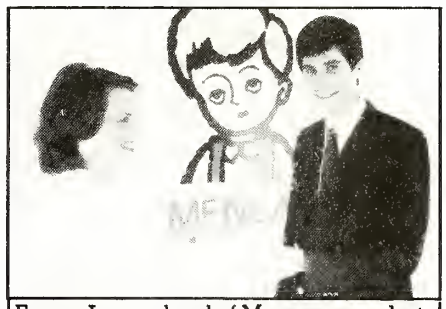
Vantage promotions to be nationally advertised on radio and in newspapers during August are:- Cosifits, Tampax (3p off-pack), Fairy soap twin, Steradent tablets, Dr White's Secrets, Poly Foam perm, Panty pads, Colgate, Body Mist 2, Silkience hairspray, Oral-B toothbrushes, Recital Colourant, Timotei shampoo (25% extra value pack), Mentadent P twin packs, Silkience shampoo, Macleans, Fresh & Dry, Family Health gripe mixture, Libra, Cream Silk and Sure antiperspirant.

Offers will be available until the end of August. *Vestric Ltd, West Lane, Runcorn, Cheshire WA7 2PE.*

ON TV NEXT WEEK

GTV Grampian	**U** Ulster	**STV** Scotland
B Border	**G** Granada	Central
C Central	**A** Anglia	**Y** Yorkshire
CTV Channel Islands	**TSW** South W'est	**HTV** Wales & West
LWT London Weekend	**TTV** Thames Television	**TVS** South
C4 Channel 4	**Bt** TV-am	**TT** Tyne Tees

Actifed: All areas except U
Aller-eze: All areas
Altacite Plus: C,A,HTV,C4
Anadin: U,BTV,Y,A,HTV,CTV,TSW, TT,(ITV,C4 and TV-am in specified regions)
Anne French: Bt
Beecham Slazenger sport range: All areas
Braun Independent curling brush and tongs All areas except TSW
Braun men's shavers: All areas
Bristol Myers Mum: All areas
Caladryl: TVS
Calgon: A,TVS,TTV
Cidal: C4(TTV,C,G)
Clairol Loving Care: All areas
Cream Silk: All areas
Cymalon: Bt
Duracell: All areas except TTV,TVS,TSW,STV
Jaap's health salts: BTV,TT,C4(TT,BTV)
Kenwood Spring: Bt
Kodak films: All areas
Lady Grecian: GTV,STV,BTV,G,Y,C,A,HTV, TSW,TVS,LWT,TT,C4
Linco Beer shampoo: All areas
Listerine: LWT,TTV,C4(LWT,TTV)
Mennen Speedstick: All areas
Optrex: All areas
Pearl Drops tooth polish: C4,Bt,Y
Photoplus Labs: Y
Poly Foam: All areas
Pond's dry skincare range: STV,G,C,A,TTV
Pond's perfect colour cosmetics: All areas
Sensodyne toothpaste: All areas
Signal toothpaste: C,TTV
Simple skin care: C4(TTV,C,A,TVS)
Sunsilk styling mousse: All areas
Vaseline petroleum jelly: Bt
Velvet toilet tissue: GTV,BTV,Y,TT

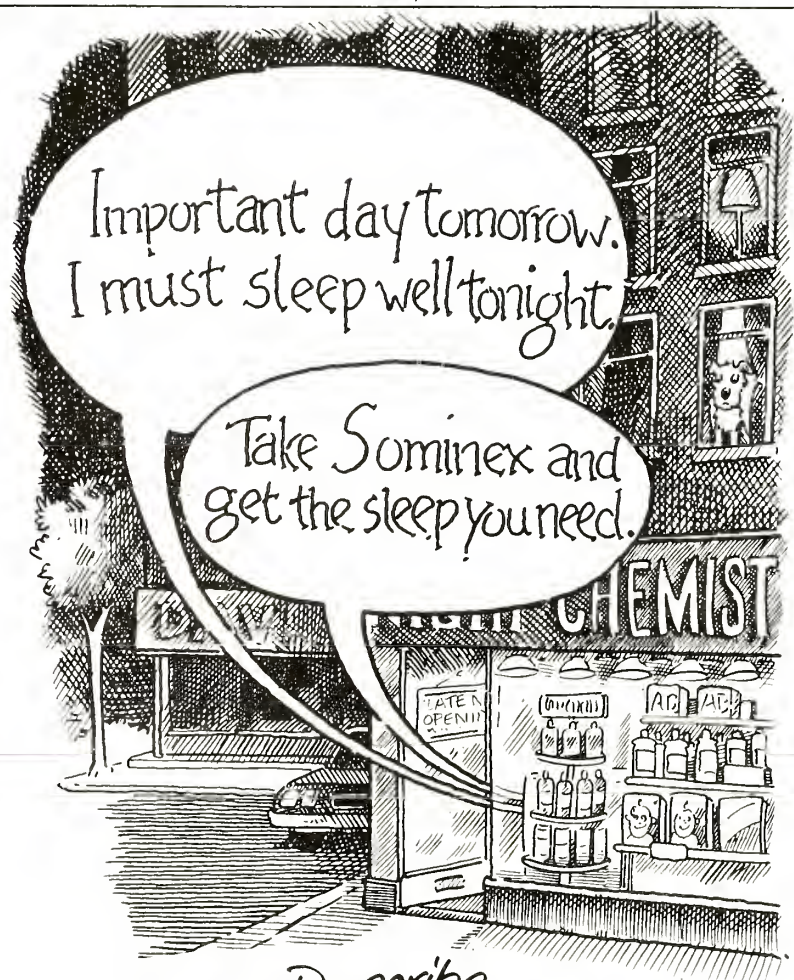


Fergus Logan, head of Mencap appeals, is presented with a cheque for £609 by Mrs Sally Hunt, group product manager of Chefaro, who recently arranged a charity programme with chemists. Over eight weeks the company donated a proportion of the cost of Confirm products ordered by chemists to Mencap. The presentation was made at the charity headquarters

Byron-national

Richards and Appleby are launching nationally a men's fragrance called Byron, following a successful test market.

Available on-shelf from September the range comprises: after shave and talc or after shave and bath and shower gel, (£2.95). Both the after shave and talc are sold separately at £1.95 and £1.25. *Richards and Appleby Ltd, Gerrards Place, Skelmersdale, Lancs.*



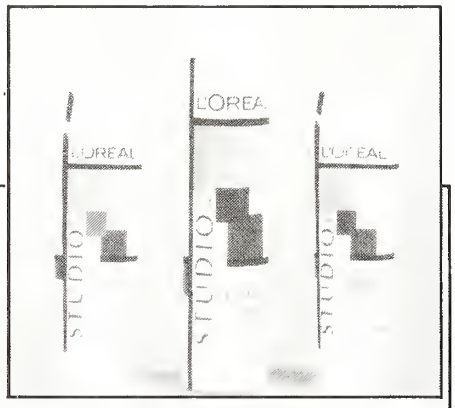
Counter Prescribe
SOMINEX
tonight's answer to temporary sleep problems.

PRESCRIBING INFORMATION Presentation: Blister pack of 8 tablets, each containing 20 mg Promethazine Hydrochloride Ph Eur **Indications:** Temporary sleeplessness **Dosage and Administration** Adults: one tablet at bedtime or up to one hour after going to bed. Children 0-16 years: not recommended **Contra-indications, Warnings etc.** There are no specific contra-indications but use in pregnancy should be avoided **Precautions:** The product is a sedative for bedtime use only. Patients should not drive or operate machinery. Alcohol and other CNS depressant drugs should be avoided **Side-effects:** A few patients may be particularly sensitive to the effects of Sominex, early morning drowsiness may be experienced, as may dry mouth, blurred vision, difficulty with lachrymation and constipation.

Product licence number 0179 0021 P

For further information write to Beecham Proprietories, Great West Road, Brentford, Middlesex

L'Oréal fix hair position



L'Oréal are reinforcing their position in the hair care market with the introduction of Studio Line styling products. The launch will be supported by a £½m television campaign.

The three products in the range — fixing spray, gel and styling gel (£1.99 each) are targetted at the younger end of the market for today's more sculpted and directional looks. The fixing spray and gel are designed to "fix a detail or hold individual locks of hair precisely in position", say L'Oréal, while styling gel "will give body and form to a style or, if used on wet hair, will achieve the slicked-back wet look". All the products are compatible in chemical composition and fragrance so they can be used in conjunction or individually.

Packaging has a high-tech look in white with primary coloured graphics. POS material includes a large window display, floor standing unit plus a counter unit and shelf reserver which both hold 12 of each gel and 10 sprays. The displays feature a picture of a young couple with wet-look and sculpted styles.

Television advertising is running on Channel 4 for the last two weeks of July and a second burst is promised for September. In the two month launch period, Studio Line consultants in major outlets will be offering a free T-shirt with two purchases from the range. *Golden Ltd, 30 Kensington Church Street, London W8.*

Apothecaries' volume 2

Using the 25th anniversary of Panadol OTC as a "happy excuse", Winpharm have produced a silver-cassetted, second volume by the Hobbypharm "Apothecaries of Jazz".

The tracks were recorded in Edinburgh during the British Pharmaceutical Conference and at the Shirley Poppy Hotel in Kent. They include "Louisiana" and "Pennies From Heaven".

Winpharm's Bernard Hardisty, who doubles as the Apothecaries' banjo player, says that copies will be available at the BPC in Leeds. The band have also been invited to play at the Edinburgh Jazz Festival on August 18 to 23, where they will appear in the programme alongside such distinguished names as Humphrey Littleton and Chris Barber. *Winpharm, 1 Onslow Street, Guildford, Surrey.*

Watching the women's Press

The following column lists advertisements for chemist merchandise due to appear in the IPC women's Press. The magazines are divided into — weeklies (W), monthlies (M) and teenager's (Y).

	W	M	Y
Elizabeth Arden Chloe:		M	
Visible Difference:		M	
Applefords Dietade fruit sugar:		M	
Ashe Maws baby products:		M	
Sherleys Pet Care:	W		
Bayer Limmits:		M	
Vita-fibre:	W		
Beechams Bovril:		M	
Germaloids:	W	M	
Germolene:	W		
Quickies:	W		
Yeastvite:	W		
Bio oil PMT:			Y
Bowater Scott Fiesta:		M	
Minima:	W		
British Chemotheutic Nylax:	W		
Care Labs Cepton:			Y
Savlon:	W	M	
Carnation low calorie soup:		M	
Chattem Mudd:			Y
Chefaro Confirm:			Y
Chesebrough Ponds cold cream:		M	
Ciba Geigy Librofem:	W		Y
Clarins:		M	
Combe Lanacane:	W	M	
Slip Stops:	W		
Cooper Health Oral B:		M	
Cow & Gate:		M	
Crookes Nurofen:	W		Y
Sweetex:		M	
Cussons Imperial Leather:	W		
Cuxson Gerrard Carnation corn caps:	W	M	
DDD Blisteze:	W		
Dentinox colic drops:		M	
Elida Gibbs All Clear shampoo:	W		
Cream Silk:	W		Y
Harmony:			Y
Impulse:			Y
English Grains Surf City:		M	
Ethicyem Witch-Stick:			Y
Eylure Elancyl:		M	
Klorane:			Y
10-0-6:			Y
Harvey Scruton Nurse Harvey:		M	
Healthilife:		M	
Health & Diet Trim 8:		M	
Heinz babyfood:	W	M	
Houbigant:		M	
ICC Anbesol:		M	
Compound W:		M	
Anne French:			Y
Immac:			Y
Preparation H:		M	
Seclodin:		M	Y
Janssen Arret:	W		
Jicca Cosmetics:			Y
Johnson & Johnson Carefree:	W	M	
Vespre:	W		Y
Kimberly Clark Boutique:			Y
Simplicity:	W		
Larkhall Labs Lipcote:		M	Y
Estee Lauder:		M	
Lilia White Contour:			Y
Dr White's:			Y
Lil-lets:			Y
Max Factor:		M	
Nelson homeopathic medicines:		M	
Neutrogena:	W	M	Y
Newton Bikini Bare:			Y
Nicholas Labs Complair:		M	
Louis Marcel:			Y
Numark:	W		
L'Oreal Belle Color:		M	
Elnett:	W	M	
Pedigree petfoods:		M	
Phillips Petcare:		M	
Proctor & Gamble Pampers:		M	
Reckitt & Colman Senokot:	W	M	
Revlon:		M	Y
Richardson Vicks Milton:	W	M	
Napisan:		M	
Rimmel:			Y
Roche Benadon B6:	W		
Helena Rubinstein:		M	
Yves Saint Laurent:		M	
Vidal Sassoon:			Y
Searle Canderel:		M	
Nutra Sweet:		M	Y
Smith & Nephew Nivea:		M	Y
Stafford Miller Sensodyne:	W		
Dr Wernets:	W		
Tampax:	W		Y
Thompson Aqua Ban:		M	
Bran Slim:	W	M	
Slimline:		M	
Thornton & Ross Zoflora:		M	
Unicliffe TCP:		M	
Unipath Clearblue:	W		
Vichy:		M	
Wella:		M	Y
Windsor Enterosan:	W		
Wyeth baby foods:		M	
Zena cosmetics:		M	

Sweet Searle in £½m TV push

Searle Pharmaceuticals are running a £½m Summer campaign for Canderel.

It breaks on August 4 and runs for four weeks on London television, Tyne Tees, HTV, TVS, TSW, Central Scotland, Ulster and Border as well as on national breakfast television. Canderel's "dolphin" commercial will be used and a four-sheet poster campaign will also run in London for six weeks. *Searle Pharmaceuticals, Whalton Road, Morpeth, Northumberland.*

Nusoft & creamy

Independent Chemists Marketing Ltd have introduced their cold cream into the Nusoft range of toiletries deleting the Lotus presentation which was in a 112gm jar.

The Nusoft cold cream will be available in a 150gm white vitrolight jar (£0.89). Member packs of 12 will cost £6.97 giving a profit of 25 per cent at standard buying terms.

A pack change has also been made to Nusoft baby powder which is now presented in a 300gm container (£0.63) replacing the 250gm size. *Independent Chemists Marketing Ltd, 51 Boreham Road, Warminster, Wilts BA12 9JU.*

Softies in Press

Super Softies which this month feature new packaging and a milder formulation (see *C&D*, June 22), are to be supported by advertising in the mother and baby Press in late Summer and an in-store promotion.

On-pack hang tabs and POS material will display the promotion offering consumers soft, coloured play bricks for four new Super Softies tabs and the cost of postage. The company reports that the product has shown 48 per cent growth in 1985. *Sterling Health, 1 Onslow Street, Guildford, Surrey GU1 4YS.*

Silk undies — Nair's province

As part of a promotional campaign to support Nair with aloe vera, Carter Wallace are running a series of competitions in provincial newspapers.

They will run to the end of August and offer prizes of silk underwear and a year's supply of Nair with aloe vera.

Publications include *Birmingham Sunday Mercury* and *Aberdeen Press & Journal. Carter Wallace Ltd, Wear Bay Road, Folkestone, Kent.*

Whole spread

Whole Earth are introducing pear and apple spread in a new recipe containing orange and lemon oils. The spread comes in 8oz (£0.74) and 12oz (£0.94) jars. *Whole Earth Ltd, Unit 29, Aceworks, Cumberland Avenue, London NW10.*

Vernaid®

THE EASILY RECOGNISABLE BRAND LEADER

The Vernaid range of high quality dressings are instantly recognisable and conform fully with the exacting standards laid down by the British Pharmacopoeia and Department of Health and Social Security.

Vernon-Carus Limited, Penwortham Mills, Preston, Lancs, England.

Vernaid® QUALITY DRESSINGS

COUNTERPOINTS

Showing they Care...

Care Laboratories are supporting Cepton with an advertising campaign and adding new POS material to both the Cepton and Cetavlon PC ranges.

Advertising for Cepton is running from now until the Autumn in teenage and women's Press, aimed at teenagers and mothers buying for their children. New POS material is available. An A4 showcard carries the message: "Prevention is better than spots," and a new A5 version reads, "This pharmacy recommends spot prevention." Tied in with this is a button badge which may be worn by the counter assistant.

New counter units carry six 250ml bottles of Cepton medicated skinwash, five bottles of lotion and eight tubes of clear gel.

The company is re-introducing the 100ml trial size of Cepton skinwash pack to retail at £0.99.

New shelf strips have been introduced for Cetavlon.

The Savlon dry antiseptic spray features in a Summer advertising campaign through July, August and September in national publications including *TV Times* and leading women's magazines, say *Care Laboratories Ltd, Lindow House, Beech Lane, Wilmslow, Cheshire.*

The Power of the Press

Power Health products are to advertise their Promerin 200, rapid breakfast, selenium gold seal and prime time protein powder in the consumer health Press. *Power Health Products Ltd, 10 Central Avenue, Airfield Estate, Pocklington, York YO4 2NR.*

Arret offer

Janssen Pharmaceutical are running a wholesale promotion for Arret, outers of 20 will be charged as 18 until the end of August. *Janssen Pharmaceutical Ltd, Grove, Wantage, Oxon.*

In the family

Vestric have extended their Family Health range to include a first aid kit (£5.99) with medicaments in a plastic box.

The kit is the first in a range expansion planned for 1985. *Vestric Ltd, West Lane, Runcorn, Cheshire.*

Holiday reading

Sterling Health have produced a leaflet urging pre-holiday visits to the pharmacy, including a check-list of items needed.

The company has also produced a puzzle pad for children recovering from illness. *Sterling Health, 1 Onslow Street, Guildford, Surrey GU1 4YS.*

Polydine licence

Polydine antiseptic soap has been given a GSL licence for treatment of acne seborrhoea, eczema, athletes foot and other skin conditions. The licence is effective from October 1.

Suppliers, Clinical Specialities plan to repackage and launch the product nationally later this year or early next. The product has been available on test only in the Midlands. The company says it intends that the soap should be sold only through pharmacy on recommendation.

Wholesalers and retailers with stocks should tell Clinical Specialities how many bars they have so that the company can send out over-stickers which can be attached after October 1. Before that date it may be sold in its existing wrapper without recommendation. *Clinical Specialities Ltd, 62 Cannock Street, Leicester.*

PRESCRIPTION SPECIALITIES

Astec generics

Generic amiloride tablets 5mg (500, £28.54 trade), cinnarizine tablets 15mg (250, £7.63), co-codamol tablets (500, £9.46), labetalol tablets 100mg (250, £14.49) and 200mg (250, £22.98), and spironolactone tablets 50mg (100, £12.30) are now available from Astec Pharmaceuticals. Minimum order value £50. *Astec Pharmaceuticals Ltd, 21a Arthur Drive, Hoo Farm Industrial Estate, Kidderminster, Worcs DY11 1BR.*

Quinocort cream

Manufacturer Quinoderm Ltd, Manchester Road, Hollinwood, Oldham OL8 4PB
Description Potassium hydroxyquinoline sulphate 0.5 per cent and hydrocortisone 1 per cent in a vanishing cream base, faintly yellow in appearance
Indications Infected eczema, intertrigo and other steroid responsive dermatoses where anti-infective cover is appropriate
Administration *Adults and children:* Massage gently over infected area two or three times daily
Contraindications Sensitivity or intolerance to any ingredients
Precautions Use with care in infants. Avoid contact with eyes or mucosal surfaces
Warnings Should not be used extensively in pregnancy. Long term continuous treatment in infants should be avoided
Packs 30g (£2.18 trade)
Supply restrictions Prescription only
Issued July 1985

BRIEFS

Flagyl in film: Flagyl tablets will be film coated, as soon as present stock has been distributed. Flagyl tablets 200mg will be slightly smaller and the 400mg tablets will be capsule shaped instead of round. Containers will change to high density polyethylene bottles. A change from Securitainers to high density polyethylene bottles for May & Baker's tablets will take place over the next few months. Flagyl and Surmontil tablets and capsules will be the first to undergo the change, say *May & Baker Ltd, Dagenham, Essex RM10 7XS.*

Extension tubes: Pharmacists are reminded that extension tubes for Duovent and Berotec inhalers are available free from *WB Pharmaceuticals, PO Box 23, Bracknell, Berks RG12 4YS.*

Antabuse tabs embossed: Antabuse 200mg tablets are now embossed "ANT" above "200", separated by a breakline, on one side, and "CP" on the reverse. *CP Pharmaceuticals Ltd, Red Willow Road, Wrexham Industrial Estate, Wrexham, Clwyd LL13 9PX.*

Co-dydramol on Paramol packs: Duncan Flockhart have changed the labels on Paramol containers to allow easier identification with the description by which it remains prescribable. The new containers emphasise the official name — Co-dydramol.

In a similar move, DF118 pack labels have been redesigned to give prominence to the BNF and "white list" description of dihydrocodeine tablets BP. *Duncan Flockhart & Co Ltd, 700 Oldfield Lane North, Greenford, Middlesex UB6 0HD.*

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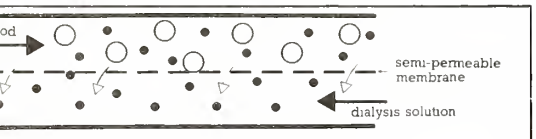
Managing endstage renal failure: renal disease 5

We have seen in previous articles that at a certain stage in the progression of chronic renal failure (CRF) the relentless decline of renal function reaches a point where life can only be sustained artificially. In the past, before transplantation became a realistic option, the only method available was a cumbersome "artificial kidney". The apparatus used in these pioneering haemodialysis procedures was massive, unwieldy and inefficient, and it was not widely available. The prospects for a patient reaching end-stage renal failure nowadays are much brighter, despite a simmering controversy in the UK over how much of the limited NHS resources should be spent on the care of renal patients.

Patients have been successfully maintained for many years on haemodialysis, with progressively more compact and efficient apparatus, so that now the filtration units themselves are little larger than the natural kidney they replace. (The associated equipment, however, is still substantial, as we shall see). The newer technique of continuous ambulatory peritoneal dialysis gives many patients much more freedom; both socially, from dependence on clinics, and medically, from symptoms. Nowadays many patients, perhaps even most, can anticipate a kidney transplant eventually becoming available and successfully functioning.

Most physicians and patients would agree that transplantion is the ideal solution to CRF, and there are diminishingly few absolute contraindications. In particular, candidates below five years or above 60 were, until recently, considered unsuitable.



g 1 Haemodialysis: diagrammatic representation of rt of one element of an artificial kidney, monstrating the principle of dialysis and the unter-current action

= movement of (unwanted) crystalloids
= large molecules (colloids)
= small molecules (crystalloids)

However, age restrictions are being eased, although advancing age generally reduces the chance of success. Transplantation is still thought unwise or unlikely to be successful in some patients with severe chronic diseases where the new kidney might be affected (eg recent tuberculosis) or, if survival is unlikely for non-renal reasons (eg cancer).

The main limitation is still the availability of suitable donor organs, and this is likely to remain so. This constraint affects the choice of patients, for both practical and ethical reasons. The decision to give a kidney to one patient often means denying it to another; the same applies to limited dialysis facilities. And how is the decision to be made? How to weigh up a 56-year-old breadwinner against a single 30-year-old for example? Of course the decision is hardly ever that stark; the system is arranged to reduce the likelihood of such agonizing decisions being too frequently thrust upon individual doctors. Nevertheless, it underlies much of renal medicine, where social, economic and ethical value judgements often take precedence over the strictly clinical.

We briefly discussed this at the start of this series of articles, but perhaps here is not the place to continue the debate. Suffice it to say that when any patient with chronic renal failure reaches the stage when their blood urea is greater than 30 mmol/l (normal = 5), their GFR falls to less than 10 ml/minute (normal = 120) or their serum creatinine approaches 500 to 1000 μmol/l (normal = 100), then in order to survive they are going to need either some form of dialysis or, eventually, a renal transplant.

Renal dialysis

Dialysis is a process in which small water-soluble molecules move passively through a semi-permeable membrane, from a solution of high concentration to a solution of low concentration (see fig 1 left). This movement can be accelerated by a pressure gradient (owing to solvent drag), when it becomes similar to ultrafiltration, because the semi-permeable properties of the membrane prevent movement of larger molcules. In biological terms, we have already seen that in the kidney the glomerular basement membrane acts as a semi-permeable membrane allowing passage of small molecules, or *crystalloids* (such as glucose, urea, sodium and potassium), into the tubular filtrate whilst retaining large plasma protein molecules, or *colloids,* within the blood. Capillary membranes perform the same function in all tissues.

The aim of renal dialysis is to provide an artificial system which performs the same functions. The two main approaches to the problem use quite different semi-permeable membranes, but both expose the blood to an aqueous *dialysis solution* which has low concentrations of the electrolytes one is attempting to remove from the blood. The two approaches otherwise differ in many important ways, including expense, convenience, efficiency, complexity and drawbacks.

In *haemodialysis,* an artifical membrane made from cellophane is used, and blood is taken from the patient's body and circulated through an artificial kidney against a counter-current of dialysis solution.

In *peritoneal dialysis* the system is much simpler, but perhaps more difficult to visualise. Dialysis fluid is introduced into the peritoneal cavity and left to equilibrate with blood passing through the extensive mesenteric (intestinal) blood circulation. The membrane is thus a natural one; in effect it is the capillary membranes of the mesenteric circulation, and the dialysis solution becomes an extension of the mesentric tissue fluid. After equilibration the fluid is drained off and discarded. The process is slow but requires far less equipment and avoids the dangers of an extra-corporeal circulation.

The two methods also differ in the way in which they deal with that most important waste product of renal patients, water. Haemodialysis removes the water quite

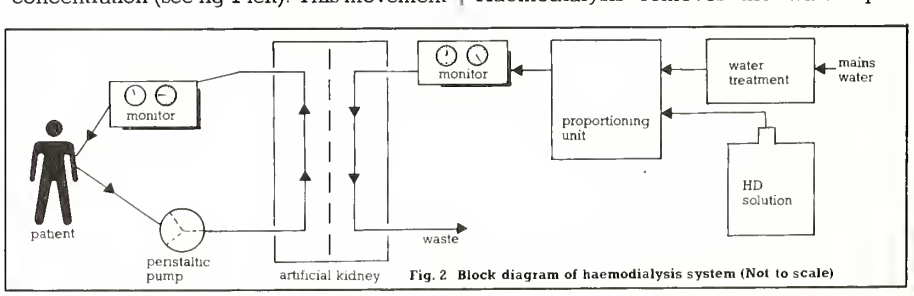


Fig. 2 Block diagram of haemodialysis system (Not to scale)

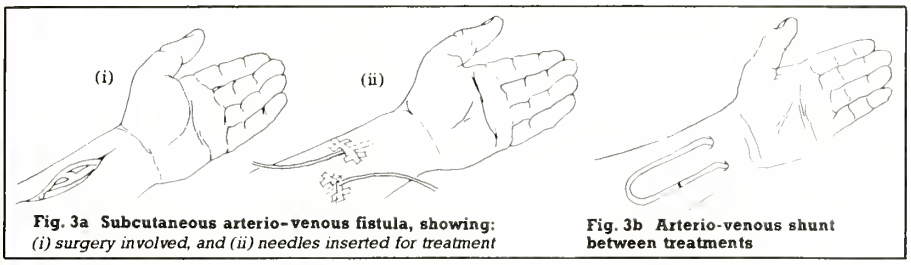


Fig. 3a Subcutaneous arterio-venous fistula, showing: *(i) surgery involved, and (ii) needles inserted for treatment*

Fig. 3b Arterio-venous shunt between treatments

quickly by ultrafiltration, because a pressure gradient is set up by the apparatus. In peritoneal dialysis the dialysis solution has variable concentrations of glucose, which acts osmotically to draw water across the membrane from the blood.

Haemodialysis:

☐ **The equipment:** About 70 per cent of dialysis patients receive haemodialysis. The early equipment was much like a filter press, with cellophane as the filter medium. Blood was passed across each "plate" of the apparatus while the dialysis medium — an aqueous solution of various electrolytes — passed continuously in a counter-current fashion on the other side of the membrane and was then discarded. The whole assembly consisted of dozens of such plates, which gave an enormous surface area but made the kidney the size of a large trunk. New developments have since reduced the size greatly, and in one version the blood is passed through thousands of very fine hollow fibres whose walls are semi-permeable; outside these fibres the dialysis solution is passed constantly through the assembly. The dialysis solution is under negative pressure, to prevent the damage to the blood.

In fact the artificial kidney itself is the simplest part of the whole system (fig 2). The complexity arises from the need to regulate the blood outside the patient's body and to control the exact composition of the water used in the dialysis solution. The blood is taken from a forearm or ankle artery and pumped gently to prevent compromising the patient haemodynamically. *Heparin* is infused slowly into the special tubing leaving the patient's arterial supply to prevent clotting in the apparatus; a bubble trap in the system prevents air entrainment, and monitors check the pressure and temperature of the blood returning to the patient.

☐ **Dialysis solution:** The dialysis solution is prepared continuously in an automatic *proportioning unit,* which mixes mains water, purified by de-ionization or reverse osmosis to remove potentially toxic trace metals such as aluminium, with *concentrated haemodialysis solution*. This solution is supplied as a 35 or 40 times concentrate, which need not be sterile as the membrane excludes micro-organisms. It provides a simple mixture of ions and alkali which, when diluted, contains the appropriate concentrations either to facilitate the removal of unwanted substances from the patient's blood or to balance substances to be retained.

The composition is critical and will vary from patient to patient. Inappropriate concentrations of *sodium* will result in rapid swings in the patient's serum sodium concentrations and cause "dialysis disequilibrium", with various CNS effects such as headaches, nausea and even seizures. The *potassium* concentration must be adjusted according to the patient's usual serum potassium before dialysis, and *bicarbonate* (usually as the pharmaceutically more stable *acetate*) will correct any acidosis. Both *calcium* and *magnesium* may also be needed. The osmotic pressure of haemodialysis fluid is not critical because the fluid is always used under negative pressure to remove water from the patient by ultrafiltration. This is more convenient and more easily adjusted to the patient's needs than altering osmolarity by varying glucose concentrations, as in peritoneal dialysis. The rate and the extent of water removal are monitored by the simple device of a *weigh-bed,* where the patient's bed is in effect a gigantic scale pan.

☐ **Home dialysis:** Most patients need haemodialysis treatment for about four to six hours, two or three times a week. Usually this is done in hospital or a special haemodialysis unit, sometimes while the patient sleeps, which reduces the disruption to his life. Indeed, many haemodialysis patients continue to work.

However, some patients have their homes specially adapted, usually with a room dedicated to the haemodialysis equipment. A special mains water supply must be arranged because each treatment may use over 200 litres of water. The patient must be well adjusted to the treatment, able to understand the monitoring and of course have someone always available to help, should any problems arise. The vascular access must also be reliable. Home haemodialysis is much cheaper than hospital treatment, and in fact has a better overall success rate, but this is because hospitals ineveitably have the more difficult cases.

☐ **Problems:** There are many potential problems with this treatment. The main ones arise from vascular access, coagulation, infection and haemodynamic imbalance.

To allow rapid and frequent access to the circulation, long term haemodialysis patients usually have a subcutaneous *arterio-venous fistula* constructed surgically (fig 3a). A major arm or leg artery is connected subcutaneously to a neighbouring vein, which eventually arterialises, ie it swells and its wall thicken. This maturing process takes a couple of months. The swollen vessels then permit easy, repeated puncture by both exit and return needles of the extra-corporeal supply, with minimal damage. Nevertheless complications are not infrequent, including infection, inflammation, thrombosis and degeneration of the vessels. Patients on haemodialysis for short periods, or while waiting for a fistula to mature, have an *arterio-venous shunt* fitted (fig 3b). The same two vessels are connected but this time via *external* plastic cannulae, which are normally interconnected between treatments. These can be disconnected and the cannulae fitted to the tubing running to and from the dialyser. This is easier to set up initially than a fistula and so can be used in an emergency, but obviously it is very inconvenient for prolonged use and is prone to blood losses, clotting and phlebitis.

Any regular vascular access, even for intravenous fluids, carries a small risk of thrombosis. In haemodialysis there is also the opposite possibility, of haemorrhage, if the heparin dose is misjudged. All patients lose some blood with each treatment, and this can be critical since they are already anaemic from the CRF. Lack of care with connection and disconnection can lead to local infection or even septicaemia.

If the reduction in body water or vascular osmotic pressure is too rapid, electrolyte disequilibria can result, causing cardiovascular and CNS problems. Inadequate treatment of the water used in the process can cause toxaemia. For example it was only recently realised that so-called "dialysis dementia" was being caused by trace amounts of aluminium in the mains water and dialysis solutions. Another potential problem is the loss of water soluble vitamins and nutrients, eg B vitamins and amino acids, to the dialysate. These must be replaced in the diet, along with iron to compensate for blood losses. The diet is still strictly controlled, especially in potassium and total fluid intake, but protein is not restricted.

Finally, both the staff and patients of haemodialysis units are constantly at a small risk of hepatitis because of frequent exposure of, or, to blood.

Peritoneal Dialysis:

The procedure for peritoneal dialysis (PD) is much more straightforward. The patient is fitted with a permanent wide bore indwelling silastic catheter, passing through the abdominal wall into the peritoneal cavity. Two litres of ready-made sterile PD solution are drained into the peritoneal cavity under

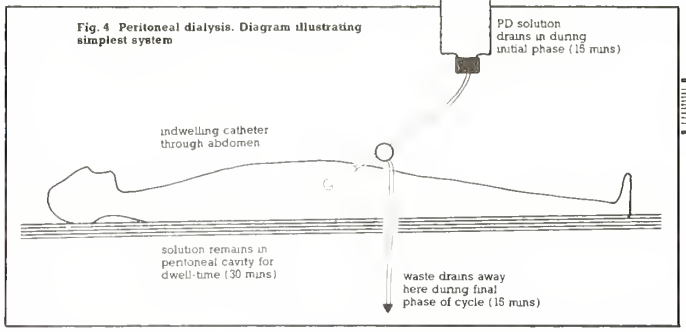


Fig. 4 Peritoneal dialysis. Diagram illustrating simplest system

gravity and allowed to remain there for about half-an-hour (see fig 4). During this "dwell time" a much less efficient but essentially similar exchange occurs between blood and dialysis solution as with haemodialysis. The main difference is that since hydrostatic pressure cannot be applied across the membrane, variable concentrations of glucose are used to draw excess water osmotically from the blood. The dialysate is then drained off aseptically, again under gravity, possibly into the same bottle. The whole cycle lasts about one hour. If this process is done *intermittently* (IPD), then to achieve an effect equivalent to six hours' HD, 10-14 cycles are needed, with a new 2 litre bottle being fitted each time. There are machines which will automatically switch the tap and connect up successive bottles of PD solution, though fig 4 shows a single cycle for clarity.

IPD is not widely used nowadays because it ties a patient to a special unit for long periods. However, it may still be required for those patients who cannot cope with other methods, such as small children, the elderly, and those with cardiovascular problems who cannot tolerate the haemodynamic stresses of HD, or for those awaiting maturation of an A-V fistula.

☐ **Continuous ambulatory peritoneal dialysis** (CAPD): In this, the currently preferred technique, 1½ to 2 litres of dialysis solution are kept in the peritoneal cavity continuously, every day. It is changed four or five times daily, with one overnight period, and the patient leads a relatively normal life between these changes.

The collapsible dialysis solution bag, after being drained into the peritoneal cavity, is folded up and tucked below a belt worn under the clothes, without being disconnected. After a minimum of four hours the dialysate is drained off into it and discarded and a new bag is connected. Obviously the bag must be somewhat oversize to contain the excess fluid generated by the process.

Although a single four-hour cycle is less efficient than four one-hourly changes, this process is overall as efficient as IPD because the fluid is in contact with the peritoneum continuously. In fact the process provides much better control than either IPD or HD: blood levels of the various waste products oscillate little, rather than rising considerably between treatments then dropping more or less dramatically during treatment as they do in these other two techniques.

The main drawback is the greater incidence of peritonitis compared with IPD, due to the greater frequency of connection and re-connection and the fact that it is done by patients rather than by experienced nurses in specialist units.

At present, there is approximately one episode of peritonitis per patient per year, and patients can only employ this technique for an average of two years before having to revert to another. Peritonitis is also the main problem with IPD. The organisms involved are usually skin commensals such as *staphylococci* and *streptococci*, or faecal organisms such as *pseudomonas* and *E.coli*.

Peritonitis is indicated by a cloudy dialysate and slow drainage, tenderness, abdominal pain, or fever. It is treated with the appropriate antimicrobial administered *in the dialysis fluid*.

Other problems with PD are related to the catheter (blocking, local infection, etc) loss of water-soluble vitamins, protein and other nutrients to the dialysate, and impairment of respiration in those with respiratory disease (since the large volume of fluid in the abdomen restricts diaphragm movement). Diabetics with renal failure can be very effectively treated by having their insulin administered intraperitoneally: it is well absorbed through the peritoneum giving smooth control of blood sugar levels.

Thus for those patients who cope with it, CAPD is the preferred method of dialysis, because of the independence it confers. When the problem of infection has been solved, for example by a simple method of ensuring aseptic reconnection, it will become the treatment of choice, for it is much less expensive than HD or even IPD. At present, however, the costs of hospitalization for infections reduce the economic advantage, and repeated infections, as well as the danger they represent to the patient, eventually render the peritoneum unsuitable for dialysis.

Renal transplantation

The majority of end-stage renal failure patients can now reasonably expect a successful transplantation, after a variable period on dialysis. For the minority whose first graft fails, a second graft usually has a better chance of survival. Renal transplantation was the first organ transplantation undertaken on a large scale and perhaps for that reason is now the most successful. Advances in immunosuppressive therapy and tissue typing have improved the outlook considerably and now a graft can be expected to survive for at least one year in 95 per cent of cases where the donor is an identical twin, and in up to 65 per cent of cases even where there was very poor matching, eg a cadaver donor.

The surgery of transplantation is not especially problematic. The kidney is sited in the left or right groin (the *iliac fossa*), its blood supply linked to the iliac artery and vein, and the ureter usually implanted into the host bladder. If possible the host's own kidneys are conserved in case the graft fails, to make the best use of any remaining function and because they may recover somewhat when rested.

The problems with transplantation arise before and after the operation rather than during it, the availability of kidneys still being the main one. *Living related donors (isograft)* account for about 30 per cent of operations. The criteria for selection of donors are stict. Some are refused because there is a poor cross match, and a cadaver kidney would be equally successful. The donor kidney may be damaged, eg due to vascular disease, or the donor's own viability would be medically compromised, eg declining renal function or systemic illness which might involve the kidneys. Some donors are judged psychologically unsuitable. There is also a small but real operative mortality risk for donors. On the other hand, healthy adults can manage perfectly well on half their normal renal capacity, and the remaining kidney undergoes compensatory hypertrophy following *nephrectomy* (removal).

Apart from better matching, living donation permits unhurried pre-operative preparation, surgery at a mutually convenient time, and a minimum time between removal and implantation, which provides a better chance of rapid restoration of renal function post-operatively.

The moral and ethical aspects of *cadaver donors (allograft)* have been discussed briefly in these articles and at length elsewhere. The majority of donors at present are the victims of "brain death", either cerbrovascular, cardiovascular or traumatic (eg road traffic accidents). Donor circulation is carefully maintained until the kidney is removed, to maintain a reasonable urine flow. Following nephrectomy the kidney is rapidly cooled and may be safely stored for up to 48 hours, although the longer it is stored, the longer it takes to recover function after transplantation. The intervening period allows time for tissue typing, cross matching and transportation.

☐ **Tissue typing:** The immune response, which is the natural defence against any foreign material *(antigen)*, be it a transplanted organ or a pathogenic microbe, depends on the ability of the host's lymphocytes to recognize the material as foreign. Each lymphocyte has receptors on its cell surface for one particular antigen, and we have a vast number in our blood, sufficient it is believed to recognize all possible antigens. Once they recognize an antigen, they divide to produce a large number of identical cells with the relevant receptor. These then attempt to neutralize the antigen, either by secreting specific antibodies (B lymphocytes) or directly attacking and engulfing it (T lymphocytes). All lymphocytes with receptors for one's own

tissue are "deleted" in the foetus stage, so that we are normally *tolerant* of our own tissues. A breakdown of this regulation is responsible for some auto-immune diseases.

So far as cellular material is concerned, what lymphocytes either recognize or fail to recognize, ie what their receptors may "fit", is some structural characteristic of the cell surface, the *antigenic determinant*. This structure is specified genetically by the cell's DNA, since DNA controls the production and characteristics of all cellular components including the cell wall. The numerous genes which determine, in a complex way, the cell wall's antigenic structure are collectively called the *histocompatability genes* and they are all located on chromosome 6. They are also known as the human leucocyte locus-A (HLA) genes. Since there are so many genes controlling histocompatability, the effect is a graded one rather than all or none. Thus the *intensity* of the immune response will reflect the *degree* of similarity between donor and host histocompatability genes.

This is the cellular basis for transplantation tolerance or rejection. If the donor's kidney cells are recognized as foreign by the recipient's lymphocytes, they will attack it. Clearly the closer the relationship between donor and host, the closer their genetic make-up and the less vigorous will be the immune response.

Special tests can be carried out with lymphocytes of known HLA type, to determine the HLA type of the donor. Thus, donors are "tissue typed" and the results sent to a computerised national or even international registry. This registry keeps records of all patients awaiting kidneys, with their HLA details. The cross matching process also takes into account blood group compatability. Another factor which seems to increase the viability of a graft, by increasing the host's immune tolerance, is a series of non-specific blood transfusions in the months before transplantation. This effect has been well demonstrated and is routinely exploited, but has not yet been fully explained.

☐ **Post-operative care:** Most living donor transplants and about half the cadaver transplants will start to produce urine almost at once. Many cadaver transplants, however, will undergo a period of acute renal failure (acute tubular necrosis) which may last a few weeks, during which the patient will need to continue on dialysis. In the absence of rejection or urological complications, most patients will be discharged within one month.

Almost all their renal problems will resolve. Fluid and electrolyte balance, uraemia, raised serum creatinine, etc, will be rectified almost at once, and anaemia and bone disease more gradually. However, they will not be completely trouble-free, and need to be monitored regularly although with decreasing frequency.

Firstly, all but identical twin transplant recipients will need maintenance immunosuppression, usually with *azathioprine* and *steroids*; thus regular blood counts and checks for steroid adverse drug reactions are necessary.

Secondly, they will usually remain hypertensive and this is managed in the usual way; in some cases removal of both original kidneys is required for control. Transplant recipients also have an increased incidence of atherosclerosis, osteoporosis, peptic ulceration and malignancy. Regular medication may be partly responsible, as may pre-transplantation damage, but the whole story is not yet known. Nevertheless, any pharmacist who has heard from a transplant patient what a difference it has made to their life, could not fail to carry a donor card, and prominently display them in his pharmacy.

☐ **Rejection:** A kidney can be rejected at any time, although the longer it survives the less likely rejection becomes. In most cases a rejection episode can be controlled by increasing the immunosuppressant dose, so that a graft may survive several such episodes and then become trouble-free. For others, the kidney may be lost and the patient put back on dialysis to await another organ. Why the rejection process waxes and wanes is not understood. A number of mechanisms are responsible for rejection, depending on the time after transplantation.

Hyperacute rejection may occur in the first few days, soon after revascularisation. It involves widespread intravascular thrombosis and cannot be controlled. The graft is inevitably lost. Since this is so prompt, it is likely that there are already antibodies present in the blood, having arisen perhaps from a previous transplantation, transfusion or pregnancy.

Acute rejection is the commonest form, occuring any time after the first few days up to several months later, but most critically after about one week. This is a lymphocyte-mediated secondary immune response, which accounts for the delay as specific lymphocytes are produced to mount a response. For the same reason it is susceptible to immunosuppressant therapy, which prevents lymphocyte proliferation.

After a few months a third type of rejection is possible. *Chronic rejection* involves obstruction of the renal vascular system, and is relentless and irreversible.

It is clearly important to prevent acute rejection and to identify it as soon as it arises. Immediately after the transplantation all patients are put onto steroids, initially IV but changing to oral as soon as possible. Formerly this was in very high doses, around *60-80mg prednisolone* a day for at least three days, gradually reducing to the continuous maintenance level of 10 mg a day over the next two months. More recently it has been found that lower starting doses of *25-30mg* have been equally effective, with a lower incidence of adverse reactions, especially infections. Cytotoxic maintenance therapy is also started at once,

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although high doses are not necessary. Usually either *azathioprine* (100mg per day) or *cyclophosphamide* (50mg per day) are used. All patients except identical twin recipients will continue with these drugs indefinitely, so regular follow-up is essential.

A *rejection episode* is marked by a fall in urine production, fever, tenderness over the graft, and a rise in blood urea and serum creatinine. However, the difficulty is to distinguish this from infection or surgical problems in the early post-transplantation period. To be on the safe side, all such events are treated as potential rejection and the steroid dosage is increased substantially. Up to *1g of methylprednisolone IV* may be given for a few days until the signs are under control, during which time other possible causes are investigated. In their absence and the failure of steroids to resolve the problem, renal biopsy may be done, but it is likely that the graft will be lost, although further increases in steroid dosage will probably be tried. Note that the dose of cytotoxic drug is not increased; the immune cells doing the damage are already in the serum, and will be unaffected by such drugs, which act by preventing their initial formation. Steroids reduce the activity of pre-formed immune cells.

Recently a number of other anti-rejection strategies have been developed. *Cyclosporin A* is a promising lymphocytostatic agent which seems only to inhibit T-cells specific for the graft. There is thus not the general immunosuppression which causes the main adverse effects of cytotoxic or steroid immunosuppressants. However, it does have its own potentially serious toxicity, notably lymphoma, hepatotoxicity and unfortunately nephrotoxicity. It is still being evaluated: in some centres it is used alone, completely replacing other agents; elsewhere it is used to allow much lower doses of conventional therapy. It certainly seems to be as effective in preventing rejection, and doubtless heralds a completely new series of immunosuppressives.

A number of immunological products are also being evaluated. The first was a non-specific *anti-lymphocyte serum* (ALS) and this approach has been refined with the isolation of a pure *anti-thymocyte globulin* (ATG, an antibody). These are produced in horse serum. Most recently there is hope of an application of *monoclonal antibody* technology; this would have the advantage, like cyclosporin, of not producing a wholesale immunosuppression.

Table 1(a): 3 year survival

Hospital dialysis	65%
Home dialysis	80%
Transplantation* — isograft	60%
— allograft	45%

*NB: This is the *graft* survival, not patient survival.

Table 1(b): Relative annual costs per patient

Hospital haemodialysis	£15,000
Home haemodialysis	£10,000
CAPD	£10,000
Transplantion	£1,500*

* + £5,000 for operation

Prognosis and costs

To complete our survey of the treatment of end-stage renal failure, we give some statistics on the relative success and costs of dialysis and transplantation (tables 1a and 1b). However, it must be borne in mind that the choice is usually based on a number of other considerations, as we have discussed.

Acknowledgement: The authors would like to thank Dr J.R. Curtis, consultant nephrologist, Charing Cross Hospital, for his helpful comments.

*** By Mr R.J. Greene, department of pharmacy, Chelsea College, University of London, and Dr N.D. Harris.**

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IN THE CITY

Retail sales cheer bleak market

This month we start a new series of stock market reports, giving the latest news and views from the City of London. Each article will describe overall market movements as well as the month's main events. All sectors will be covered but we plan to give special emphasis to pharmaceutical companies. We will also give a few forecasts and indications of where we think you might be able to make good investments.

The month started on a dismal note, after the worst week for a year, which saw a 24.6 point drop in the *FT* ordinary index to 939.

Electronics companies are spreading doom and gloom. At Thorn EMI Peter Laister resigned as chairman and chief executive, GEC disappointed the market with an increase in profits of "only" £45m and STC warned of a first half loss.

As well as electronic worries, investors were anxious about the adverse effect on exporters of the rise in sterling against the dollar and the queue of new issues set to absorb institutional cash.

OPEC's indecision added to the unhappy mood. That has not deterred Government from going ahead with the sale of its remaining 49 per cent shareholding in Britoil. The shares will have to be priced cheaply, say at about 185p, to take account of uncertainties in the oil market but, once the sale has taken place, they could be very good value.

In the private sector several new issues, including Cambridge Instruments, were called off. Chrysalis, the record company, went ahead but perhaps regretted it as the issue flopped badly. Isotron, who offer a gamma ray sterilisation service for medical and other purposes, were however, warmly received by the market.

One cheering factor has been the good retail sales figures. The consumer boom seems to be lasting much longer than analysts were expecting a year ago. Against this background, Boots issued their accounts which confirmed the progress the company has made on the retail side (*C&D,* June 8).

It looks as if the retail operation will continue to make most of the running. The pharmaceuticals business will be hit this year by the expiry of ibuprofen patents in the US.

Brokers' views on Boots vary. De Zoete & Bevan rate the shares at 193p a buy, Phillips & Drew say they are a "hold" and Capel-Cure Myers recommend a switch out of Boots in favour of other retailers.

There was plenty of takeover activity during the month. Burtons raised its offer for Debenhams to £553m, but even this was rejected by the company, and Arthur Bell continued to slang it out with its bidder, Guinness.

Other bid candidates include TI (formerly Tube Investments) where Evered, a recently revived engineer, plus various other parties declared an 11 per cent stake, and Allied-Lyons where an Australian brewery has built up a small shareholding.

The flood of rights issues looks likely to subside as both Hanson and English China Clays had difficulty getting their issues away successfully.

As the month ended, there seemed little reason to expect a big recovery. Although lower by half a percentage point, interest rates are still high. And with sterling at more than $1.40 exporters are starting to worry about keeping up the profit growth. August could be a different story.

BEECHAM PROPRIETARIES

Prices effective from 19th August 1985

Product Description	Sales Status	Retail Price per Unit Incl. VAT	Units per Case	Standard Wholesale Price Per Case Excl. VAT
		Pence		£
ALL FRESH				
Clean Up Squares (10 sachet)	–	60	12	4.78
DIOCALM				
Standard (20 tablets)	PCD1	135	12	10.76
Large (40 tablets)	PCD1	215	6	8.57
GERMOLOIDS				
Suppositories Std (12)	GSL	117	12	9.33
Suppositories Lge (24)	GSL	209	3	4.17
Ointment (25g)	GSL	119	12	9.49
Toilet Tissues	–	99	6	3.95
MACLEAN INDIGESTION REMEDIES				
Tablets Std (24)	GSL	83	12	6.62
Tablets Lge (48)	GSL	135	6	5.38
Powder Lge (50g)	GSL	135	6	5.38
PHENSIC (*ALSO SOLUBLE PHENSIC)				
*Strip (6 tablets)	GSL	30	36	7.17
*Handy (12 tablets)	GSL	50	24	7.97
*Standard (24 tablets)	GSL	87	24	13.87
Medium (50 tablets)	P	123	6	4.90
Large (100 tablets)	P	199	6	7.93
QUICKIES				
Face Cleansing Small	–	63	12	4.93
Face Cleansing Large	–	76	12	5.95
Face Cleansing Jar	–	147	6	5.75
Eye Make-Up Remover Small	–	63	12	4.93
Eye Make-Up Remover Jar	–	147	6	5.75
Nail Varnish Remover Small	–	63	12	4.93
SCOTT'S EMULSION				
New Large (500ml)	GSL	410	6	16.04

All prices marked PCD1 or P or GSL are Resale Price Maintained.

P: Sale is restricted to persons lawfully conducting a Retail Pharmacy business or to holders of a Wholesale Dealer's Licence (Medicines Act, 1968) for sale to the lawful conductor of a retail pharmacy.

PCD1: As P above except that wholesalers must also be registered under Schedule 1 of the Misuse of Drugs Regulation, 1973.

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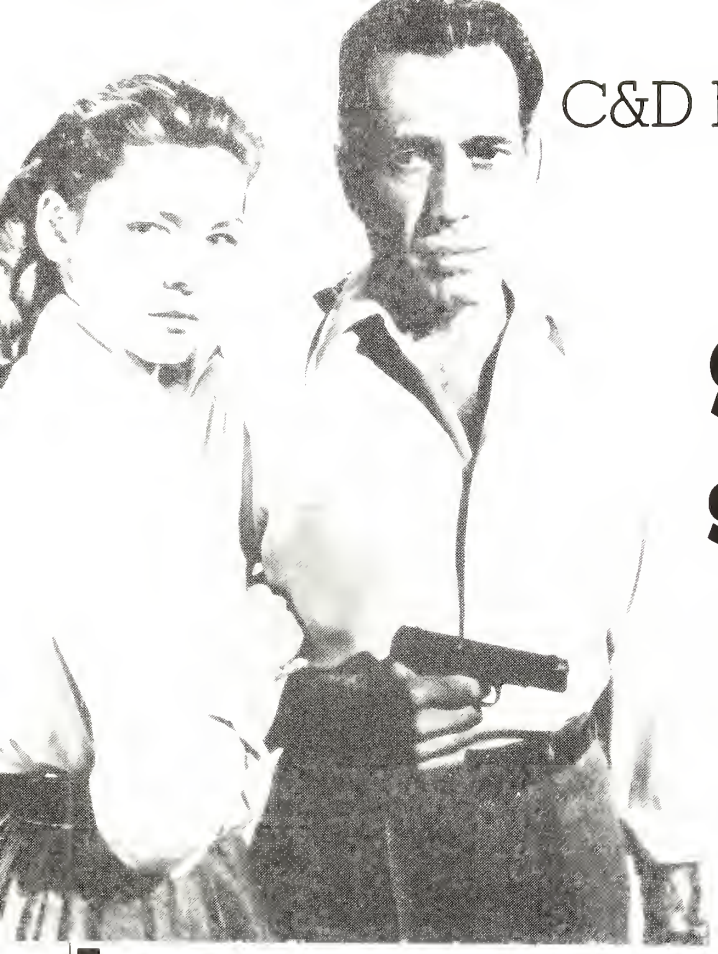

Sniffing out the scent pirates

"The pebbled glass door panel is lettered in flaked paint: **'Philip Marlowe...Investigations'.** *It is a reasonably shabby door at the end of a reasonably shabby corridor in the sort of building that was new about the year the all-tile bathroom became the basis of civilisation. The door is locked, but next to it is another door with the same legend which is not locked. Come on in — there's nobody here but me and a big bluebottle fly." — Raymond Chandler,* **The Little Sister.**

Bogart and Bacall: That image is just for the movies, says Vincent Carratu

If you think all private detectives work from offices like those described by Raymond Chandler, you're wrong.

Carratu International's headquarters is a featureless square building a little way from the main shopping street in London's Worcester Park. The offices themselves are modern, smart and comfortable.

Vincent Carratu's inner sanctum has three framed documents displayed on the wall. Pride of place goes to a message of thanks from the Hong Kong Police — Carratu headed their 1981 corruption inquiry there. Matters had come to a head with the death of a local police inspector, supposedly a suicide. "He'd somehow managed to shoot himself five times in the chest, if you remember.

"Then there was the Van Der Morrell job, where we were working with the Dutch police. That involved a multimillionaire who disappeared while in the Bahamas. We were hired by the company he worked for to find out what had happened to their missing chairman. Eventually, we were able to show he'd been murdered and defrauded out of a great deal of money. But we managed to find the person responsible and get him put away."

The Carratu agency was also involved in early investigations of the Klaus Von Bulow case, working on this occasion for relatives of Von Bulow's wife.

Another Carratu investigation which made the headlines was the recent break up of a ring making counterfeit Chanel perfume worth around £7m. The agency was involved here in finding where the fake fragrance was being made, and gathering the evidence that would eventually be used in court. Mr Carratu himself posed as a potential buyer in the final move which allowed police to arrest the gang.

"We were involved from the beginning right through to the very end" he recalls. "Myself and the staff involved did a hell of a lot of travelling, all round Europe and the Middle East, the States and Mexico.

"We've been working for Chanel since the early seventies. They're very important clients of ours. I've got good staff and very good co-directors, so I don't do as much legwork as I used to. But now and again, our special clients appreciate the personal touch.

"Chanel are a very aggressive company too — they really fight to protect their name. It's so valuable of course. You *have* to fight to protect a name with that kind of power."

One of the services a private detective sells is his discretion. So Vincent Carratu is understandably reluctant to say too much about cases currently in progress. "My problem is talking about clients who have problems, because not all of them want the world to know that."

He is prepared to say, though, that a recent trip abroad — which had forced us to cancel an earlier appointment — was made for a client operating in *C&D*'s field. Carratu's showroom of fake goods includes packs made ostensibly by Estée Lauder, Chanel, Charles of the Ritz, Colgate-Palmolive, Elida Gibbs and Revlon.

"If you've got a product name that people know, then someone else will try and cash in on it. It's as simple as that."

Carratu International's role in counterfeiting cases is usually to gather evidence that a trademark is being infringed. "Before you can go to court, you need direct evidence they're actually trading with your name. It could be that we simply pick up some of the phoney product on the market, or trace a big order, or get hold of some of the makers."

Part of the problem is that it's very easy to make counterfeit perfumes — far easier, say, than trying to put together an imitation Rolex watch. "And there are so many people around quite prepared to make the bottles, print the packaging and so on. What gets put inside is anyone's guess."

Victims of the counterfeiters, the companies who find their products endlessly imitated, say the answer is to make counterfeiting a criminal offence, as has already happened in America.

"It's much better in America now. The FBI get involved in counterfeiting cases, and the penalties they can call on are phenomenal — you can go to prison for a long, long time. Where persistent offenders are involved, they can even throw the key away, which has a very salutary effect."

As English law now stands, counterfeiters have to be charged with conspiring to cheat or defraud. If the legal definition of conspiracy is not satisfied, the case may get no further.

"I'm afraid the police are now very reluctant to get involved in cases of counterfeiting. I'm not criticising the police, because they've got a lot on their plate, but they don't want to take cases to court, get involved in a long trial, and then find the judge throws it out on a technicality."

Mr Carratu has had personal experience of the frustrations facing the police. He was a detective constable with the Fraud Squad when he decided to go it alone 22 years ago. The business was very much a one-man band in those days.

Carratu International now has offices in London, Birmingham, New York, Paris, Johannesburg and Rome. A lot of their early work came through contacts Vincent Carratu had built up during his time at Scotland Yard, and with Manchester's Fraud Squad. Counterfeiting started to become an important part of their work in 1966.

"It was all fraud work before that — we aren't inquiry agents as such. We don't do divorce work, or debt collection, or process served or anything like that.

"Some agencies, for example, specialise in debt collection work, highly important, but very much a different area. Divorce work and all the rest is different again.

"But 90 per cent of our work finishes up in a criminal court, so we tend to work quite closely with police forces all around the world." Most of the money needed to initially get the business off the ground came from an overdraft. Had the bank manager been reluctant to fund a private eye business?

"Strangely enough, it wasn't too bad. I had a certain reputation then, and a lot of people knew me from the work I'd done."

Since then, new clients have found the business mostly by word of mouth. From the very earliest days, they've worked with multinational companies, probably because they're among the most vulnerable targets for counterfeiters.

Carratu's New York office was their first overseas base. "We got to the stage where, if you added up all the journeys we made in a year, there would be about 26 or 27 trips. And most of the appointments were in New York, so we just thought 'This is ridiculous, we ought to be over here'."

A police background is a useful qualification for potential investigators, Mr Carratu believes. Experience in the armed forces can also be helpful.

"Services people are used to just packing a bag and disappearing to some far-off place, whereas policemen tend to be much more parochial. That's not to say they don't adapt well, but military people do it as a matter of course.

"When I'm recruiting, the first thing I look for is an extrovert personality, because the guy's going to be meeting and dealing with a lot of different types. He's got to be able to work on his own initiative, and not be afraid to take chances. The worst thing you could do is have someone who gets nervous when things get hot. And he must be literate, because whatever we do, we have to be able to put it all down on paper.

"We went into the rest of the suite, which contained a rust-red carpet, not very young, five green filing cases, three of them full of California climate, and an advertising calendar. There were three near-walnut chairs, the usual desk with the usual blotter, pen set, ash tray and telephone, and the usual squeaky swivel chair behind it. 'You don't put on much of a front' she said." — Raymond Chandler, **The Big Sleep.**

"The other thing about an armed services background is that they've had the training to look after themselves. You don't have to have a black belt. That's not necessary, because if it actually comes down to violence, you've blown your cover anyway. But where it is important is in giving the person confidence.

"I was involved in a job, many years ago, where I lived under cover as a member of this gang for nine months. That was pretty hairy because we weren't in this country. We spent a lot of time travelling together in the Middle East, myself and five or six of them.

"I hate to think what would have happened if they'd found out who I was.

"I'll be honest, I don't know if I'd like to do it now. But I was much younger then, and the old adrenalin was flowing..."

Now he's mostly behind a desk, Mr Carratu is very concerned to change the profession's image. "You say you're a private detective, and a lot of people go 'Where's your belted raincoat, and do you feed the pigeons on the windowsill?'. So we encourage clients to come here and see that we're a professional set up."

"We have an Institute of Professional Investigators, with about 300 members, and I'm the principal. One of the things we're trying to do is persuade Government there should be some licence controls, because there *are* a lot of cowboys in this business.

"Some of the methods these guys use would make your hair stand on end.

"I'm not thinking so much of rough stuff, though I'm sure that happens in debt collection and so on, but even in our area they think nothing of breaking and entering to get their evidence."

The institute also runs training seminars for its members. "We had one in New York recently, which dealt with researching company files and reading accounts. There was another on getting photographic evidence."

The thought of a professional association and training seminars somehow makes the idea of being a private eye sound disappointingly ordinary. Doesn't any of the romance of films like "The Big Sleep" and "The Maltese Falcon" survive in real life?

"Not really. You travel a lot, yes. Our chaps average about eight months of every year away, and they do go to some exotic places. But they're working ten or 12 hours a day while they're over there, so they don't see anything.

"One of our chaps has just got back from Thailand — which sounds marvellous. Poor chap, all he saw was Bangkok, and he saw all the seedy bits of that."

Phillip Marlowe charged his clients $40 a day plus expenses. Carratu International also base their charges on how long a particular case takes.

"That's the only way you can do it, because you never know how long a job's going to take. What we normally do is get the client to agree to an initial fee limit, then try to complete the investigation within that limit."

Given that, can he say anything about how much his involvement in the Chanel case cost the company? "You must be joking. All I can tell you is that it was a very expensive exercise."

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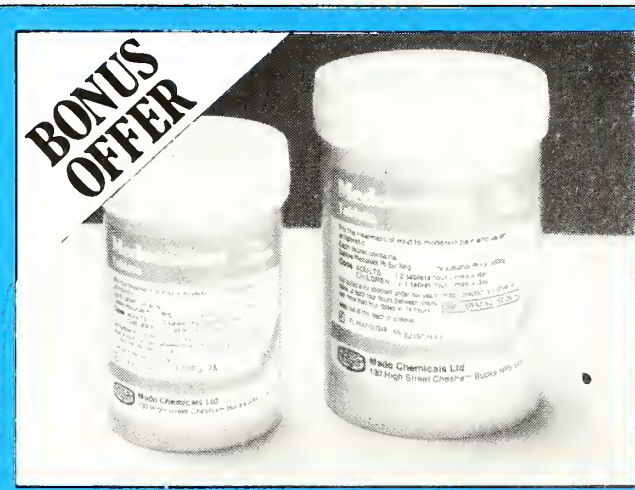

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PAC fight the good fight

It was very gratifying to read in last week's issue that the Pharmaceutical Society's Council is now back-pedalling on its rapturous welcome for the new contract package. And the points over which it has expressed serious misgivings are the very ones PAC has fought for since its inception: unfair discrimination against small pharmacies; the fact that it will be virtually impossible for any young pharmacist to buy his own business. PAC also believes that an NHS contract cannot be withheld from any properly qualified individual; leapfrogging cannot be prevented.

Nobody will doubt this *volte-face* has been the result of pressure exerted by PAC. We revealed the true implications of the proposals and pricked the consciences of Council members over the immorality and injustice of what was being put forward. And PAC will continue to keep up the pressure until the proposals are abandoned and equitable ones put in their place.

The Minister for Health must be equally aware of the strength of feeling in the profession, although last week he tried to play down the strength of the protest.

It is becoming clear to all pharmacists that PAC is the only organisation to offer any hope for their future, as the only body that is prepared to fight for the ordinary pharmacist.

Alan Nathan
Chairman, PAC

Underwoods 'take out' contract

Now that the opening battle on the new NHS contract is virtually over, and the political and legal ones remain, it is worthwhile to take stock of the situation.

A severe cut is on offer for several thousand contractors and a quite ludicrous increase of 0.76 per cent for others, both peddled by the PSNC as a necessary evil to obtain the perceived good of the restriction of entry.

The Minister has, however, confirmed that there is no intention whatsoever of writing into the guidelines such words as to clearly prevent leap frogging. What, therefore, has the PSNC achieved?

As the Minister is aware very little money will be saved in this present exercise, Indeed it is our contention that costs will increase as a result of the back-up staff required for the dozens of committees throughout the country. Should we not pause to consider very carefully what medium term intention lies behind the Minister's action. Might he not, for instance, say next year: "The maximum the Treasury wishes to spend is £xm. You have control over numbers, if you increase so be it, but divide the sum up as you will".

Restriction of entry will achieve only one result, the demise of the independent, brought out by the aggressive multiple (including ourselves), and an increase in drug store and supermarket chains selling an extended general list. A pharmacist will have one hand tied behind his back, others will not; they will multiply more readily at this profession's expense.

We have personally appealed several times to each and every member of Council to reject this contract as damaging to the profession as a whole.

We confirm again that this company has no serious commercial concern in the outcome of these pathetic negotiations. We have, however, witnessed serious abuse of the democratic process in other trades and their unions in the 1960s and 1970s, and feel duty bound on behalf of our own honourable profession to oppose such unfair and un-democratic measures as this new contract contains, and not least, the means by which it was proposed.

We ask all pharmacists and students to consider the views put forward in these columns over the past weeks and come to their own conclusion. *You are* still able to affect the issue by writing to Council and to your Member of Parliament expressing your view. If you care you should do it now.

B.P. Kerner, MPS
Chairman and md, Underwoods
H. Woolf, MPS
Founder and former chairman

Abusive help

During the programme "Drugwatch" on BBC-TV (see *News*) two things caught my attention. The first was that so many addicts described the attitude of their GPs as "unhelpful", the second was that pharmacists were only mentioned once throughout the two hour programme.

The attitude of many GPs is understandable if not commendable; addicts are undeniably "bad news" to everyone who has to deal with them. But I would have thought that pharmacists, as the experts on drugs, would have a role to play in combatting this menace.

I have not heard that the Pharmaceutical Society or National Pharmaceutical Association are doing anything to organise community pharmacists in an anti-drug abuse campaign, perhaps they do not feel it is their duty to do so. If this is so I feel that it is up to individual pharmacists to organise themselves. I would like to hear from anyone who thinks as I do on this matter.

R.S. Medley
Weston-super-Mare

Keep it simple

I have read letters in various journals about providing drug information for patients.

It seems pharmacists are more worried than the patients themselves about what information to provide. In my opinion, the information on prescribed drugs, other than cautionary warnings should only be made available on request. It seems silly to publish booklets telling patients what the drug is for, how it works, and what its bioavailability and pharmaco-kinetics are. Patients, after all, are not always interested in these details; besides, it confuses them.

Some patients who have read about a drug and its indications in "MIMS" have come back to pharmacists or doctors complaining they have been issued with the wrong drug. Patients don't always need to know how these drugs work. We all use electrical equipment and we don't always know its mechanism of operation. Nor do we need to know.

We ought to be aiming to make life easier for patients and not to flood their minds with flashy pharmaceutical jargon, especially when they don't need to know.

D.A. Shah
Nottingham

Time for ESPs

I am pleased to note that, unlike the Pharmaceutical Services Negotiating Committee, the Pharmaceutical General Council (Scotland) has wisely chosen not to rush into a decision on the new contract until the final details are available.

I hope this will allow time to get Essential Small Pharmacies in Scotland the same deal as in England and Wales. "A network of essential small pharmacies serving mainly ruraly areas" is surely just as important in Scotland. So I can see no reason why we should be simply "no worse off than under the existing remuneration procedures" rather than receive the guaranteed minimum income offered in England and Wales.

I appeal to all Scottish pharmacists who agree with me that we should not have to accept second best, to write to the PGC and their MP on this matter.

Graeme Park
Johnstone, Strathclyde

Prospects bright for AAH pharmaceutical business

AAH's pharmaceuticals distribution business — excluding Vestric — increased profits by 61 per cent to £2m in the year to March 31. Sales were up 26 per cent at £93m.

No account of Vestric's performance appears in the results, as AAH completed their purchase of the company only two days before their year end. The group will say, however, that Vestric's performance more than matched the trading profits forecast of £5.5m, which they made at the time of the acquisition.

Herbert Ferryman and Northern Pharmaceuticals were both bought in January. They contributed post-acquisition trading profits of £124,000 on sales of £8.8m.

"The pharmaceuticals division successfully met the challenge of unremitting price competition, and produced substantially better results overall" says chairman Bill Pybus.

AAH already owned Hills Pharmaceuticals, Hill Smith (Warrington) and Mawson & Proctor before embarking on this year's buys. These established businesses, say AAH, reached a new peak.

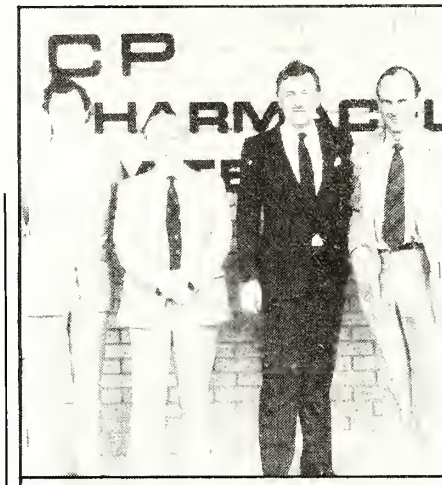
The group as a whole saw sales rise 3.9 per cent to £521.1m. Despite their main business of fuel distribution being hit by the miners' strike, profits rose £779,000 to £11.25m.

Fuel distribution contributed 64.5 per cent of AAH's sales, and 57.9 per cent of profits. Pharmaceuticals (still without counting Vestric) contributed 17.8 per cent of sales and 15.5 per cent of profits.

The group's balance sheet has been included with the results, in order to reflect the increase in assets and reserves coming from the acquisition of Vestric.

This shows current assets of £193.78m (1984: £97.91m), and current liabilities of £145.95m (£71.63m). Reserves doubled to £446.6m.

Buying Vestric was the main event of the past year, says Bill Pybus. "As a result, the size and shape of the group has undergone a fundamental change, and we are now entering a promising new era".



Nicholas Edwards, Secretary of State for Wales, has just paid a visit to CP Pharmaceuticals at their Wrexham headquarters to see the expanded facilities there. Mr Edwards was shown round the laboratories of the company — a Fisons subsidiary — by (left to right) Geoff Shaw, managing director of Fisons UK, Clive Albany, MPS, CP's director of technical operations and technical manager Ian Williams, MPS

Too much help for Avon ladies?

NPA director Tim Astill says he couldn't be happier with Government proposals to take under-21s out of the wages council system. "Lord Young's suggestions are very much in line with the representations we made" he says. "Almost word for word, in fact".

The only part of Lord Young's earlier plans for putting the "Burdens on Business" report into affect which is causing concern at the National Pharmaceutical Association is the idea of making life easier for home-workers.

"Our philosophy is that there should be no more restrictions on business than are needed to protect the taxpayer and the consumer" says Mr Astill. "And the Enterprise Unit White Paper seems to take the same view".

But he's worried that any further changes in the law may give Avon ladies, Sunday markets and Tupperware parties an unfair advantage over the more established trader.

"They've got no need to worry about planning permission, no Government inspectors coming round, no problem with VAT and much lower overheads. What we don't want to see is the burden lifted in such a way as to give these people an unfair advantage over our members".

The Retail Consortium has welcomed the White Paper's proposals, though they warn over-simplification in consumer protection could lead to innocent shopkeepers being prosecuted.

Red tape fight moves to EEC

The Government is taking its fight to reduce the regulations affecting small business to the EEC.

Proposals from the UK's representatives in Europe suggest changes to proposed legislation, together with a series of modifications to existing European Commission law for small firms.

They want to see the minimum number of employees an employer must have before having to consult with the unions on redundancies increased from 10 to 100, and small firms made exempt from the legislation which requires men and women be treated equally.

They are also calling for legislation safeguarding employees' rights when a company changes owners to be scrapped.

The document's other proposals assume it will prove easier to amend upcoming legislation than to drop existing rules — which may already have been adopted as domestic legislation in individual member states.

Suggested new restrictions which the British delegation want to see scrapped cover improvements to the pay and benefits of part-time workers, parental leave for men and women, equal treatment for self employed men and women, employee consultation and worker participation on the board. All should be abandoned, they say.

They also suggest dropping some safety, consumer and company law changes.

Ibuprofen hiccup for Boots in US

Boots have suffered a legal set-back in the States in its marketing plans for ibuprofen.

A number of US generic manufacturers have been working on a generic version of the drug, which went out of patent in May. Boots applied for an injunction to stop one company marketing the drug, claiming it had infringed Boots' patents in its development work.

But a West Virginia judge has rejected the application, saying pre-patent testing on drugs was common practice. He also criticised attempts by Boots to swamp the market with its own generic product.

Boots plan to appeal.

Dixon's 1984 figures show £400,000 profits for Barclays

Dixons' distribution arm — which includes Barclays — saw sales fall £7.3m to £70.6m in the year to April 27. Pre-tax profit from the division was a third lower at £400,000.

The other company in Dixons distribution operation is Permaflex, who deal in butane gas refills and snuff. Dixons say they had "another successful year".

Barclays have closed five depots since the beginning of the year, in Coventry, Stoke, Newport, Sheffield and Newtownabbey. In January, they reported first-half sales rising £4.5m to reach £39.9m. Profits were down on the previous first-half's £194,000, however.

Dixons themselves say they have "substantially reduced" their investment in pharmaceutical wholesaling, and point out that they now trade only from their Grimsby depot.

Turnover for the parent group rose 73 per cent to reach £606.7m. Some £190m of this came from the acquisition of Currys in November last year. Pre-tax profits were up 93 per cent at £39.6m. Currys contributed £8.6m, after interest payments from the buy.

Dixons own retailing operation brought in sales of £275.4m (£216.6m), with profits of £22.2m (£14.8m). The group's processing business had sales of £30.3m, £10.9m higher than the previous year, and profits up £980,000 at £1.3m.

"Last year I said unequivocally that I have never been more optimistic about the future growth of Dixons" says chairman Stanley Kalms. 'That remains my unambivalent view".

High Street trouble ahead?

Out-of-town shopping centres could mean that High Street's days are numbered, says National Consumer Council chairman Micheal Montague.

In the NCC's annual report, Mr Montague describes as "worrying" the tendency in major retail companies' plans for the 1990's to concentrate on complexes with generous parking space. He stresses the importance of neighbourhood shops to the elderly and those without cars.

"It seems to me that planning authorities need to take a more robust view of shopping needs. The local authority for every village, town and city should have a positive strategy and not simply let time and tomorrow's trade pass by".

Another cause of concern to the NCC is the steady drop in the number of small shops, both in country and inner city areas. The Scottish and Welsh Councils have urged the government to give regional development grants for retailing: "This battle is not yet won".

"Absurd" is the NCC's view of shop hours restrictions, but it is "increasingly optimistic" that legal controls will be abandoned, following Parliament's acceptance of the Auld Report.

The Council welcomes the Insolvency Bill, including its suggestion that abuse of customer prepayments and responsibility for company collapses should indicate a director's unfitness to run another company. Also welcomed is the end of the optician's monopoly, although the NCC is "concerned" about the limited provision of NHS spectacles.

Nationalisation call from Labour

Resolutions calling for complete nationalisation of the British pharmaceutical industry, the abolition of all charges for health care and an end to private medicine will go before the Labour Party conference in October.

Among other resolutions are that:
FPCs should be wound up and replaced by "democratic district committees" consisting of two-thirds lay members and one-third representatives elected by members of TUC affiliated unions;

That there should be further investment in primary care to enable GPs to employ staff solely for preventive services;

That patients become more involved in their own health care by the encouragement of patient participation groups between patients and doctors;

That there should be a campaign to increase public awareness of the dangers of drug and solvent abuse and more resources for treatment of addicts.

Commons 'OK' on EEC liability

Government moves to bring British law on liability for defective products into line with that of other members states of the EEC got Commons approval last week.

During the debate on an EEC draft directive on product liability, fears were expressed about the implications of the adoption of the concept of a "developed risks defence" for manufacturers of defective products.

Paddy Ashdown (Liberal) described the adoption of such a defence as a "black hole" which would result in consumers of products such as Thalidomide or Opren having little chance of protection from the courts.

Alex Fletcher, under secretary for corporate and consumer affairs, explained that a defective drug, in the context of the new regulations, would be one which did not provide the safety that could reasonably be expected of it, taking all of the circumstances into account.

The directive has been welcomed by the Consumers' Association. The draft directive would extend to manufacturers the liabilities retailers already have to their customers. "The directive should mean that consumers will have a better chance of getting compensation from manufacturers for damage or injury caused by faulty goods," says CA director Peter Goldman.

Briefly...

Bio-Medical Services have changed their phone number to 0904 422583.

Paterson Products have decided to close their offices in London's Boswell Court, and rehouse sales, accounts and administration functions in Dagenham.

Medicare — Reed Executive's drugstore operation — contributed sales of £21.437m in the year to March 30. Operating profits reached £342,000. The equivalent figures for 1984 were £20.358m and £201,000. The company opened eight branches during the year, adding a further four since the end of March. They now have a total of 44 stores.

COMING EVENTS

Thursday August 1

Pharmacists Against the Contract. York Room, Bonnington Hotel, Southampton Row, London WC1, at 7.30pm. All welcome. Coffee and biscuits.

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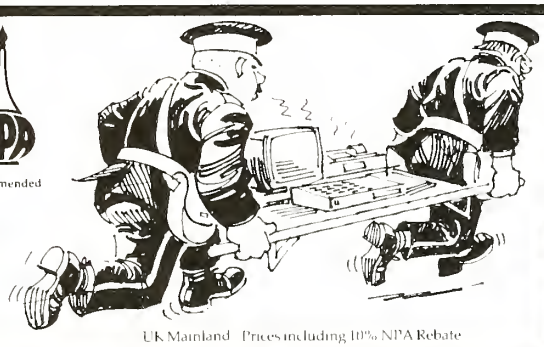

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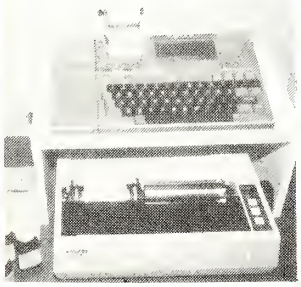

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PAC names the names

Pharmacists Against the Contract have announced the names of the people who make up their regional committees in Leicester and Cardiff.

The Leicester Committee is chaired by Mr Jayanti Patel and comprises Mr Suryakant Patel, Mrs Sudha Patel, Mr Bharat Maru, Mr Sudhir Ruparelia, Mr Shailesh Panchamtia and Mr Navit Parmar.

In Cardiff, the committee is chaired by Mr Roger Davies and consists of Miss Julia Hughes, Ms Lynn Hargrave, Mr Robert Hargrave, Mr Balbir Virdee and Mr Eric Taylor.

Di chooses the alternatives

The Princess of Wales told district pharmaceutical officer Terry Naidens of her interest in allternative medicine when she opened a new wing in Lincoln County Hospital.

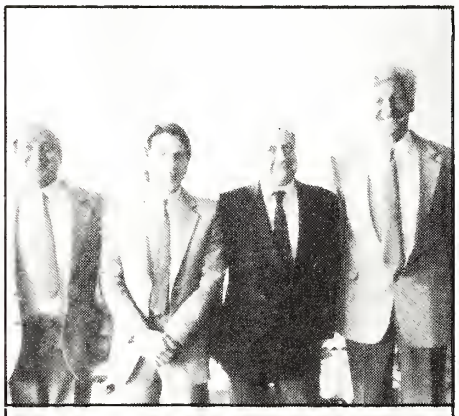
During a tour of the £17m development, the Princess suggested a move into the field of acupuncture.

"I joked that we pharmacists may be a bit concerned about jobs if alternatives to drugs were used" said Mr Naidens. "We told the Princess that we already have one medical person at the hospital who, among other things, does do acupuncture here."

25 years in wholesaling

Mike Devall is celebrating a 25th anniversary this year. Mr Devall, manager of Unichem's Rutland Road, Sheffield branch, has spent a quarter of a century in pharmaceutical wholesaling.

He says the business has changed out of all recognition since Unichem bought his father's wholesale business in 1971. J.H. Holden Ltd — which is now the Rutland Road branch — was Unichem's first acquisition. In those days we serviced the chemists and allied trades twice a day in Sheffield and South Yorkshire, and we had a total staff of 30," he says.



The second team to reach the Numark golf final for the Rennie trophy is from Scotland. William McFarlane MPS, (left) won the qualifying round at Rosemount and James Taylor MPS (second left) came second. Cyril Westgarth (right) of Numark wholesaler Raimes Clark (Edinburgh) is the third team member, and Ken White of Nicholas Laboratories was on hand with congratulations

Four firsts

Four students at the University of London Chelsea College have obtained first class honours degrees in pharmacy this year. They are: Mark Adrian Grainger, Karen Louise Roberts, Harminder Sandhu and Angela Weller.

Students gaining second class honours, upper division degrees totalled 23, and 24 graduates obtained second class honours, lower division. Three students obtained pass degrees.

Mrs Steer of Rossiters pharmacy, Tiverton is on her way to Puerto Rico, Gran Canary for a week as the fourth winner of the Swain/Kodak Canary competition. Peter Chambers, commercial director of E.E. Swain presented Mrs Steer with her prize. The competition is open to anyone buying 100 rolls of Kodak film from Swain of Hunstanton. Adrian Lemmon was the fifth winner of the competition. Mr Lemon of Reads Pharmacy, Norwich, wins a week's holiday for two on Gran Canary

The wheel thing

For the fourth time running — or rather biking — *C&D* contributor Eric Jensen has completed the London to Brighton bike rally, held annually in aid of the British Heart Foundation.

Mr Jensen's youngest son, Bob, also took part and made sure he had plenty of company on the way. He and a blind friend rode a tandem and his son went along in a specially fitted seat.

Mr Jensen, who writes *C&D's* "Pharmacy Economics" series, says the rally is a pleasant day out and he intends to go on joining the thousands of participants for many years to come: "Eventually I hope to be the oldest person taking part."

Jumping to £1,250

A group of highfliers from BFN storefitters decided to take to the skies for charity recently. Each of the 27 employees made a sponsored parachute jump from 2,000ft above Headcorn airfield in Kent. Their efforts landed over £1,250 for the North West Kent Hospital.

Records not to be sniffed at

Smelly records are the latest idea from Environmental Frangrance Technologies, a division of Charles of the Ritz.

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The player retails at £15.95 and the records at £2.95, each one, says the company, filling an average room and lasting for over 100 three-minute "playing times" The company is selling the product in to department stores and "selected outlets".

Michael Munro left Crown Chemical Co as administrative director to become chief executive and secretary of the Animal Health Distributors Association, not as reported last week. He was sales director at Crown Chemical Co until 1977.

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